Northern Lincolnshire and Goole NHS Foundation Trust

Inspection report

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

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

Summary of findings

Background to the trust

Northern Lincolnshire and Goole NHS Foundation 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).

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

The trust has 830 inpatient and critical care beds across 44 wards and operates approximately 460 outpatient clinics and 164 community clinics per week. The trust employs around 5,200 members of staff.

The trust operates from three hospital sites;

- Diana, Princess of Wales Hospital
- Scunthorpe General Hospital
- Goole and District Hospital

The trust provides the following community health services in North Lincolnshire;

- Adults
- Dental
- End of life care

North Lincolnshire Clinical Commissioning Group (CCG), North East Lincolnshire CCG and East Riding of Yorkshire CCG commission the majority of the trust's services, based on the needs of their local populations.

CQC has carried out a number of inspections of the trust; the last comprehensive inspection of the acute services was in November 2016. We rated safe and well led as inadequate, effective and responsive as requires improvement and caring as good. We rated the trust as inadequate overall. In January 2017 we issued a Section 29A warning notice which stated that the quality of health care provided by the trust required significant improvement. We had significant concerns relating to staffing shortages, the lack of patient assessment and/or escalation of patients and insufficient management oversight and governance of the identified risks. Following the last inspection, the trust was placed in quality special measures in April 2017. We issued requirement notices in regard to compliance with Regulation 9: person centred care, Regulation 10: dignity and respect, Regulation 11: need for consent, Regulation 12: safe care and treatment, Regulation 17: good governance and Regulation 18: staffing. The trust put an action plans in place, which has been monitored by CQC through regular engagement with the trust.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Requires improvement 

What this trust does

Northern Lincolnshire and Goole NHS Foundation trust provides a range of acute hospital-based and community services to a population of more than 350,000 people across North and North East Lincolnshire and East Riding of Yorkshire.

Summary of findings

The trust has 830 inpatient and critical care beds across 44 wards and operates approximately 460 outpatient clinics and 164 community clinics per week. The trust employs around 5,200 members of staff.

The trust operates from three hospital sites;

- Diana, Princess of Wales Hospital
- Scunthorpe General Hospital
- Goole and District Hospital

The trust provides the following community health services in North Lincolnshire;

- Adults
- Dental
- End of life care

We inspected all services provided by this trust because at our last inspection we rated the trust overall as inadequate. Following the last inspection the trust was placed in special measures in April 2017.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we 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 the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected all services provided by this trust because at our last inspection in April 2017 we rated the trust overall as inadequate. Following the last inspection the trust was placed in special measures.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed Is this organisation well-led?

What we found

Overall trust

Our rating of the trust improved. We rated it as requires improvement because:

We rated well-led as inadequate. We rated safe, effective and responsive as requires improvement. We rated caring as good.

Summary of findings

Our rating of Diana Prince of Wales Hospital stayed the same. We rated it as requires improvement. We rated two of the hospital's nine services as good, six as requires improvement and one as inadequate.

Our rating of Goole and District Hospital went down. We rated it as requires improvement. We rated three of the hospital's five services as good, one as requires improvement and one as inadequate.

Our rating of Scunthorpe General Hospital improved. We rated it as requires improvement. We rated two of the hospital's nine services as good, six as requires improvement and one as inadequate.

Our rating of the trust's community services went down. We rated community health services as requires improvement. We rated two of the three services as requires improvement and one as good.

- We rated well-led for the trust overall as inadequate. This was not an aggregation of the core service ratings.

Are services safe?

Our rating of safe improved. We rated it as requires improvement because:

- The trust did not always have appropriate numbers of staff to ensure patients received safe care and treatment. The trust had introduced some additional staff and roles and used agency staff to provide cover and mitigate some of the risk to patients. Medical staffing was not in line with national and professional recommendations in a number of services.
- We were concerned about the number of serious incidents (SIs) within the medical service. Staff received feedback and shared learning from serious incidents was evident but ward managers did not receive collated information about other incidents, to learn from themes and trends.
- There was limited evidence that services staff had the skills, training and experience to provide the right care and treatment. For example, mandatory training rates in the majority of the trust's services were below the trust target of 85%.
- We found that some staff did not manage medicines in line with trust policy or national and professional guidance.
- The previous inspection found that clinical validation (clinical prioritisation) and assessment of risk within outpatients waiting lists had been slow to be implemented across all specialities. The trust had started to clinically validate some waiting lists; however, this was inconsistent and not complete across waiting lists in all specialities.
- We found examples in medical care and outpatients where there had not been sufficient effective senior clinical oversight to manage risks to patients.

However:

- The trust had acted on most of the concerns in the Section 29A warning notice that was issued after the inspection in November 2016.
- At the previous inspection, we had highlighted that the five steps to safer surgery including the World Health Organisation (WHO) checklist, was not used effectively. During this inspection we saw improved practice and from our observations it was clear that the checklist was embedded as a routine part of the surgical pathway.
- We saw improvements in the process to identify patients at risk of sepsis and those that were deteriorating. We saw that staff had completed records correctly and saw evidence of appropriate escalation.
- Procedures were in place to refer and safeguard adults and children from abuse. Staff felt confident making a safeguarding referral and relevant staff received safeguarding supervision.

Summary of findings

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- Not all services provided care and treatment based on national guidance. There was variable participation and outcomes in local audit and national audit and we found action plans did not always address the effectiveness of the care and treatment patients received.
- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Training compliance in relation to the Mental Capacity Act was unavailable for some services and did not meet the trust target in others.
- Appraisal rates for staff were worse than the trust target in the majority of services.
- The trust did not provide seven-day services in line with national guidance. Not all patients received a senior medical review every day, particularly at weekends.

However:

- Patients were provided with adequate food and drink. Individual preferences were taken into account. Initiatives had been implemented to try and improve patient's nutrition. Pain relief was offered to patients and reviewed to identify its effect.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Are services caring?

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

- Staff involved patients and those close to them in decisions about their care and treatment. We heard patients being given clear instructions in a caring manner and staff provided emotional support to patients to minimise their distress.
- Feedback from the patients and relatives we spoke with was positive. We observed care and interactions which were kind and compassionate and patient's privacy and dignity was maintained at all times, sometimes in difficult circumstances.
- In relation to patients with mental health problems we observed staff demonstrating a non-judgemental attitude towards them and described assessing patients' needs on an individual basis which would include both mental and physical health.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- At our 2016 inspection we had concerns about the number of patients overdue their appointment. During this inspection we found there were 31,295 patients overdue their follow up appointment as at March 2018. This was worse than the previous inspection. During this inspection we found there were still patients without an appointment due date.
- The previous inspection found issues with referral to treatment (RTT) indicators. During this inspection we found that referral to treatment indicators were not met across all specialities. There was no clear plan for recovery or a trajectory to improve referral to treatment performance.
- There were 320 patients waiting over 52 weeks for an appointment at the trust as at March 2018. There was no clear plan for recovery or a trajectory to improve the 52 week wait performance.

Summary of findings

- The trust was performing worse than the 85% operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral. There was no clear plan for recovery or a trajectory to improve the 62 day cancer pathway performance.
- Patient flow through the hospitals remained an issue with a significant number of patients cared for on non-medical or non-speciality wards (outliers). Delayed transfers of care, delayed discharges, bed moves at night and mixed sex accommodation breaches remained a concern in medical care.
- Services did not always manage and investigate concerns and complaints in line with the trust's policy.

However:

- Staff understood and met the individual needs of patients. We heard examples of how staff supported vulnerable patients including those living with dementia or learning disabilities.
- Following our inspection, the trust provided evidence of a draft RTT trajectory which had been incorporated into the trust's 2018/19 operational plan submission in April 2018.

Are services well-led?

Our rating of well-led at core service level improved. We rated it as requires improvement because:

- At this inspection we saw improvements in some of the trust's services but some services had deteriorated since our previous inspection.
- The Trust did not have a leadership or talent management strategy but had taken some action to develop leaders since our previous inspection.
- The executive team acknowledged there was a significant amount of work to do to establish accountability and effective clinical leadership throughout the organisation.
- The Trust did not always have a systematic or timely approach to quality improvement. A number of the risks we identified at this inspection were ongoing issues that we had found at previous inspections, the pace of change in the organisation was not at the rate we would have expected since previous inspections.
- We found some examples of where the board and leaders were not fully sighted on some of the risks in the organisation. This did not give us assurance about the flow of information and escalation of risk from 'ward to board.'
- We had some concerns about the ability of staff at all levels in the organisation to recognise where and when improvements were required in their own services.
- Divisions did all not have a vision, strategy or business plan. There was limited evidence at divisional level of effective engagement with patients, staff, and the public to plan and manage services.

However:

- Overall, we saw improvements within the emergency departments and maternity services and the trust had acted on most of the concerns in the Section 29A warning notice that was issued after the inspection in November 2016.
- The trust had reviewed its governance structures and processes as part of the work to improve clinical leadership and accountability in the organisation.
- Staff felt well supported by their local leaders and morale in the trust was beginning to improve in most services.

Summary of findings

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in critical care throughout the trust, in medical care at Scunthorpe General Hospital and Goole and District Hospital, community dental and community end of life services.

For more information, see the outstanding practice section of this report.

Areas for improvement

We found areas for improvement including six breaches of legal requirements that the trust must put right. We found several things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the areas for improvement section of this report.

Action we have taken

We wrote to the trust twice under Section 31 of the Health and Social Act 2008 to consider whether to use CQC's regulatory powers to impose or vary registration conditions. We did this because we had reasonable cause to believe that, unless CQC acted people would be or may have been exposed to the risk of harm. The letters were in relation to the trust's insufficient management, oversight and governance of the risks to patients within the outpatient's service. The trust responded to the letters and provided detailed information on how they are going to manage the waiting list backlog. CQC will continue to monitor this.

We issued six requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

For more information on action we have taken, see the sections on areas for improvement and regulatory action.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Training had been provided by the critical care service for 20 paramedics of a local ambulance trust in taking blood cultures and administering intravenous antibiotics. This initiative had received recognition by the UK sepsis trust.

The vascular specialist nurses were using new technology to site central lines. Historically it could take two to three hours to site a line and confirm its position by x-ray before it could be used. With this technology lines could be used within an hour meaning treatment could be delivered to patients much quicker.

Staff from the community dental service were heavily involved in local oral health promotion initiatives. These included the oral health promotion team visiting special schools, mental health units and residential homes to provide oral hygiene advice. They also provided oral hygiene advice to health visitors, nursery nurses and residential home staff.

Summary of findings

One dental nurse we spoke with told us they had designed and produced a leaflet highlighting the importance of maintaining a healthy mouth. This leaflet had been distributed to local schools.

Neuro rehabilitation centre therapies staff conducted vocational visits with patients for example to a person's workplace, to support their rehabilitation.

Staff in the community end of life service were focused on the holistic needs of their patients and carers. They worked with external partners to meet these needs. For example, the service worked with the local authority to deliver clean linen free of charge for those patients receiving palliative care.

The development of a respiratory in-reach service and a Saturday clinic at SGH for chronic obstructive pulmonary disease (COPD) patients had helped the service meet its 48 hour follow up standard and had improved patient outcomes.

The frail elderly assessment team (FEAST) demonstrated positive outcomes and had been shown to be reducing unnecessary hospital admissions for frail elderly people, enabling them to stay in their own homes and facilitating community care. Due to its success this model was to be developed out at DPoW hospital.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

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

Trustwide

- The trust must ensure they have evidence to show that complete employment checks for executive and non-executive staff have been taken in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).
- The trust must ensure that effective and robust systems are in place to support the management of governance, risk and performance.
- The trust must establish accountability and effective clinical leadership throughout the organisation.
- The trust must develop a clinical and financial strategy that addresses the delivery of safe and sustainable services.
- The trust must ensure complaints are addressed in line with the trust policy.

In urgent and emergency services:

Trustwide

- The trust must continue to appropriately recruit medical staff to ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. The department was not in line with the Royal College of Emergency Medicine (RCEM) guidance of providing 16 hour consultant cover.
- The trust must ensure that all staff complete mandatory training to meet the trust's set standard of 85%.
- The trust must ensure that all staff have an up to date appraisal completed.

Diana Princess of Wales Hospital

Summary of findings

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

Scunthorpe General Hospital

- The trust must appropriately recruit staff (specifically paediatric trained nurses RSCN) and ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients.
- The trust must review the training requirements needed for registered nurses and emergency nurse practitioners in relation to children.
- The trust must review the risks within the department and increase compliance with paediatric training and risks associated with no registered sick children's nurses.
- The trust must ensure that all patient's records contain relevant safeguarding information and referred to the safeguarding team as appropriate where there is evidence of risk.

In medical care:

Trustwide

- The trust must ensure safe medicines management; that there is adequate pharmacy support to all areas, that staff practice in line with policy and ensure staff are clear about what are reportable medicine incidents and are encouraged to report them.
- The trust must define and complete the vision and strategy for the medical services in a timely manner.
- The trust must provide assurance of risk registers being actively managed and overseen.

Diana Princess of Wales Hospital

- The trust must ensure learning from serious incidents is shared with staff and that learning is embedded to prevent similar incidents occurring in the future.
- The trust must ensure medical and nursing staff comply with mandatory training requirements and are appraised annually.
- The trust must ensure safe medical staffing levels are maintained and every effort is made to recruit to vacancies. This should include reviewing the current hospital at night arrangements and ensuring patients are reviewed daily.
- The trust must improve areas of care identified as needing improvement from national and local audits.
- The trust must improve the trust's referral to treatment time (RTT) for admitted pathways for medical patients.

Goole and District Hospital

- The trust must ensure robust arrangements are in place to ensure sufficient, effective senior clinical oversight to manage patient risk and take appropriate action to respond to urgent or changing needs.
- The trust must ensure nursing staff carrying the emergency bleep receive the training regarding expectations and actions to take to lead a site-wide emergency response out of hours, as soon as possible.
- The trust must ensure staff apply trust policy and guidance to care effectively patients with on-going need for enteral nutrition (naso-gastric (NG) or percutaneous endoscopic gastrostomy (PEG) feeding).

Summary of findings

- The trust must implement a programme of nursing audits, monitoring and equipment checks at GDH to provide assurance that appropriate care and safety standards are being met.
- The trust must ensure timely repair and maintenance of estates and facilities issues at GDH.

Scunthorpe General Hospital

- The trust must ensure learning from serious incidents is shared with staff and that learning is embedded to prevent similar incidents occurring in the future.
- The trust must ensure medical and nursing staff comply with mandatory training requirements and are appraised annually.
- The trust must ensure safe medical staffing levels are maintained and every effort is made to recruit to vacancies. This should include reviewing the current hospital at night arrangements and ensuring patients are reviewed daily.
- The trust must improve areas of care identified as needing improvement from national and local audits.
- The trust must improve the trust's referral to treatment time (RTT) for admitted pathways for medical patients.

In surgery:

Trustwide

- The trust must ensure that service risks are identified, reviewed, updated and senior management teams have oversight.
- The trust must define and complete the vision and strategy for the surgical services in a timely manner.
- The trust must ensure that 95% of staff have an up to date appraisal in line with their own target.
- The trust must ensure that mandatory training compliance for all staff meets their own target.

Diana Princess of Wales Hospital

- The trust must ensure that performance in all national audits improves and that action plans address the correct issues to ensure performance improves.
- The trust must improve on national treatment performance standards.
- The trust must ensure that there are sufficient qualified, competent, skilled and experienced persons to meet the needs of patients using the services.
- The trust must ensure that patients are fasted pre-operatively in line with best practice recommendations.
- The trust must ensure that medicines are prescribed and administers in line with national guidance.
- The trust must ensure that effective processes are in place to reduce the number of cancelled operations.
- The trust must ensure that policies and guidelines in use within clinical areas are compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies.
- The trust must continue to 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 (2015).

Goole and District Hospital

- The trust must ensure that all patient records are completed in line with professional and trust standards.

Scunthorpe General Hospital

Summary of findings

- The trust must ensure that effective processes are in place to enable improvement on the number of fractured neck of femur patients who have surgery within 48 hours.
- The trust must ensure that performance in all national audits improves and that action plans address the correct issues to ensure performance improves.
- The trust must improve on national treatment performance standards.
- The trust must ensure that there are sufficient qualified, competent, skilled and experienced persons to meet the needs of patients using the services.
- The trust must ensure that patients are fasted pre-operatively in line with best practice recommendations.
- The trust must ensure that effective processes are in place to reduce the number of cancelled operations.
- The trust must ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies.
- The trust must ensure timely repair and maintenance of estates and facilities issues within the operating theatre department.
- 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 (2015).

In critical care:

Trustwide

- The trust must ensure there are plans to enable medical staffing to meet Guidelines for the Provision of Intensive Care Services (GPICS) 2015 recommendations.

Diana Princess of Wales Hospital

- The trust must ensure nursing and medical staff are fully compliant with mandatory training requirements.
- The trust must ensure all nursing and medical staff have undergone an annual appraisal.
- The trust must ensure they are confident that nursing staff in within critical care are competent and have the required training and skills, whilst working towards the GPICS recommendation of 50% of staff having a post registration award in critical care nursing.

Scunthorpe General Hospital

- The trust must ensure all staff are aware of the fire evacuation procedure on the intensive care unit (ICU).
- The trust must ensure assessment of mental capacity is formally recorded particularly when restraint is used and that all staff have received training.

In maternity:

Trustwide

- The trust must ensure all staff are up to date with their mandatory training, including Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoL's) training and safeguarding training.
- The trust should ensure all staff have an annual appraisal in line with their policy.
- The trust must ensure the community midwifery staffing caseloads are in line with national and professional guidance (a ratio of 96 cases per whole time equivalent midwife).

Summary of findings

Diana Princess of Wales Hospital

- The trust must ensure consultant staffing on labour ward is in line with the Royal College of Gynaecologist (RCOG) guidelines.
- The trust must ensure they are able to evidence 1:1 care in labour.

Scunthorpe General Hospital

- The trust must ensure they are able to evidence 1:1 care in labour.

In services for children and young people:

Trustwide

- The trust must ensure staff are up to date with mandatory training.
- The trust must ensure that medical staff are up to date with safeguarding level three training.
- The trust must ensure that children and young people with a mental health condition are risk assessed for their mental health needs, self-harm or suicide and are cared for in a safe environment that has been appropriately risk assessed.
- The trust must ensure that staffing on the paediatric assessment unit meets national guidance.
- The trust must ensure that staff are appropriately trained in caring for children and young people with mental health conditions.
- The trust must ensure that staff are up to date with appraisals.
- The trust must ensure that they are meeting national standards for medical staffing

Diana Princess of Wales Hospital

- The trust must ensure that access to the paediatric assessment unit is secure.
- The trust must ensure that the paediatric assessment unit has access to its own resuscitation trolley.

In end of life care:

Community

- The trust must ensure that all staff receive an annual appraisal.

Diana Princess of Wales Hospital

- The trust must ensure that all patient records are completed fully, particularly regarding MCA and do not attempt cardiopulmonary resuscitation (DNACPR).
- The trust must monitor the effectiveness of care and treatment provided.
- The trust must ensure that sufficient numbers of palliative care staff are employed to provide care and treatment.
- The trust must ensure that all incidents are recorded appropriately.
- The trust must provide services over seven days.
- The trust must ensure that all staff complete mandatory training, including safeguarding training.
- The trust must ensure that policies are reviewed and updated in a timely manner.

Summary of findings

Scunthorpe General Hospital

- The trust must ensure that an effective system is in place to monitor equipment in the mortuary.
- The trust must ensure that all patient records are completed fully.
- The trust must monitor the effectiveness of care and treatment provided.
- The trust must ensure that sufficient numbers of palliative care staff are employed to provide care and treatment.
- The trust must ensure that all incidents are identified for the service and managed appropriately.
- The trust must provide services over seven days.
- The trust must ensure that all staff complete mandatory training.
- The trust must ensure that complaints are identified for the service and managed appropriately.

In outpatients:

Trustwide

- The trust must put in place a robust and effective clinical validation system for the assessment of patients within the outpatient backlog that is prioritised based on clinical risk and covers all specialities.
- The trust must ensure that the patients from the 2016 backlog have had an appropriate follow-up appointment.
- The trust must put in place a clear plan for recovery with milestones and trajectory to address the backlog of patients waiting for follow up appointments in outpatients.
- The trust must put in place a clear plan for recovery with milestones and trajectory to improve the referral to treatment performance.
- The trust must put in place a clear plan for recovery with milestones and trajectory to improve the 62 day cancer pathway performance.
- The trust must put in place a clear plan for recovery with milestones and trajectory to improve the 52 week wait performance.
- The trust must complete a formal review of the deaths of 181 patients who died whilst on the waiting list to consider if the delay in appointments or treatment delay contributed to their death.

Diana Princess of Wales Hospital

- The trust must ensure patient records are completed in line with professional standards and trust policy.
- The trust must ensure records are stored securely in outpatients.

Scunthorpe General Hospital

- The trust must ensure patient records are completed in line with professional standards and trust policy.
- The trust must ensure records are stored securely in outpatients.

In diagnostic imaging:

Trustwide

- The trust must ensure that all staff receive appraisals in a timely manner to meet the trust target of 95%.

Summary of findings

- The trust must ensure that medical staff are up to date with all of their mandatory training to meet the trust target of 85%.
- The trust must carry out further work to improve reporting times for x-rays and scans.

Diana Princess of Wales Hospital

- The trust must address the scanning access, break down, reliability and quality issues faced by the radiology and diagnostics departments.
- The trust must ensure that the five year vision and strategy are enacted and work towards getting back on schedule so as to impact on waiting and reporting times and ensure visions of the future of the department are action planned and put in to practice.
- The trust must continue to recruit radiologists and reporting radiographers to address staff shortages and reduce reporting times.
- The trust must carry out further work to improve waiting times for patients to receive scans and x-rays, including routine scans.
- The department must improve the robustness of its escalation of untoward x-ray and scan results to ensure no patients experience delayed diagnosis or treatment.

Scunthorpe General Hospital

- The trust must address the scanning access, break down, reliability and quality issues faced by the radiology and diagnostics departments.
- The trust must ensure that the five-year vision and strategy are enacted and work towards getting back on schedule so as to impact on waiting and reporting times and ensure visions of the future of the department are action planned and put in to practice.
- The trust must continue to recruit radiologists and reporting radiographers to address staff shortages and reduce reporting times.
- The trust must carry out further work to improve waiting times for patients to receive scans and x-rays, including routine scans.
- The department must improve the robustness of its escalation of untoward x-ray and scan results to ensure no patients experience delayed diagnosis or treatment.

Community dental services:

- The trust must ensure emergency equipment is available in line with nationally recognised guidance.
- The trust must ensure emergency medicines and equipment are in date.
- The trust must ensure that equipment used in the provision of the service is maintained appropriately.
- The trust must ensure the storage infection control procedures follow nationally recognised guidance.
- The trust must ensure that an effective system is in place for checking emergency medicines and equipment.
- The trust must ensure an effective system is in place to check when equipment used in the provision of the service requires servicing.
- The trust must ensure their audit processes remain effective.

Summary of findings

- The trust must ensure that systems and processes are implemented to identify risks and take action to mitigate these risks.

Community health services for adults:

- The trust must ensure that there are sufficient qualified, competent, skilled and experienced staff to meet the needs of people using the services.
- The trust must ensure that all non-medical prescribers receive regular supervision from a Designated Medical Practitioner (DMP) as per trust policy. Supervision must include regular monitoring, review and discussion of their prescribing history to ensure this is safe and effective.
- The trust must also ensure that prescription pad use and storage is audited for all non-medical prescribers.
- The trust must ensure that all staff receive an annual appraisal and regular supervision in line with trust policy to provide them with support and enable staff access to the training and development they need to improve services to patients.
- The trust must ensure that patients are able to access services in a timely way, especially in the continence service, the unscheduled care team and therapy services.
- The trust must ensure that community nurses are using a recognised and effective risk assessment tool to assess the risk of pressure damage to patients.
- The trust must ensure that staff receive feedback on incidents and lessons learnt are shared across the wider teams.
- The trust must ensure that lessons learnt from complaints are shared with all staff.
- The trust must ensure that there is a robust strategy for community health services for adults, developed with involvement from staff, patients, and key groups representing the local community.

Action the trust SHOULD take to improve:

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services.

In urgent and emergency services:

Trustwide

- The trust should review the pathways and patient group directions that require updating.
- The trust should continue to improve the RCEM audits to achieve the required standard.
- The trust should ensure that strategies are implemented to allow medical staff in ED to work with other specialities so they can manage the flow in the department.
- The trust should ensure that they are meeting the required complaint timescales.

Diana Princess of Wales Hospital

- The trust should review the environment provided for children to ensure they have waiting and treatment areas that are separated from adult patients.
- The trust should ensure that medicines and fridge temperatures are monitored and escalated when they are not within normal parameters.
- The trust should review the designated mental health room and complete regular risk assessments of the room.

Summary of findings

- The trust should review the training requirements needed for registered nurses and emergency nurse practitioners in relation to children.
- The trust should develop further communication with the GP provider to allow patients to be managed in the most appropriate health care setting.
- The trust should continue to develop the frailty service at the hospital to support elderly and frail patients to be cared for in the most appropriate place.
- The trust should ensure that patients mental capacity is assessed.

Scunthorpe General Hospital

- The trust should encourage staff in the department to participate in initiatives across the hospital and department.
- The trust should continue to increase the compliance to 100% within the ED nursing dashboard.

In medical care:

Diana Princess of Wales Hospital

- The trust should consider how themes and trends from lower harm incidents can be shared to improve practice.
- The trust should continue its work to improve patient flow throughout the hospital to reduce the number of ward moves, moves at night and outlying patients and ensure patients are cared for in the right place by the right speciality team.
- The trust should continue its plans to develop the cardiology area which will facilitate single sex accommodation and reduction in the number of mixed sex accommodation breaches.
- The trust should continue to promote a caring culture and engage staff to address any residual issues of bullying and intimidation and involve staff in ongoing service improvements.

Goole and District Hospital

- The trust should continue to work with partners to reduced delayed transfers of care and consider reviewing non-urgent transport arrangements for patients needing to attend one of the other hospital sites for investigations.
- The trust should consider reviewing its management and governance arrangements for the neuro rehabilitation centre to ensure effective governance, monitoring, risk management and service delivery, on the unit.

Scunthorpe General Hospital

- The trust should consider how themes and trends from lower harm incidents can be shared to improve practice.
- The trust should continue its work to improve patient flow throughout the hospital to reduce the number of ward moves, moves at night and outlying patients and ensure patients are cared for in the right place by the right speciality team.
- The trust should continue its plans to develop the respiratory ward area which will facilitate single sex accommodation and reduction in the number of mixed sex accommodation breaches.
- The trust should continue to promote a caring culture and engage staff to address any residual issues of bullying and intimidation and involve staff in ongoing service improvements.

In surgery:

Diana Princess of Wales Hospital

Summary of findings

- The trust should continue to ensure that effective processes are in place to enable access to theatres out of hours, and that all cases are clinically prioritised appropriately.
- The should continue to ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions.
- The trust should continue to ensure that patients are assessed for delirium in line with national guidance.
- The trust should ensure that staff complete Mental Capacity Act training.

Goole and District Hospital

- The trust should take steps to improve its staff and public engagement activities.
- The trust should display information to staff, relatives and patients on current safety performance.

Scunthorpe General Hospital

- The trust should continue to ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medicines are checked on a daily basis in line with the trust's policy.
- The should continue to ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions.
- The trust should continue to ensure that resuscitation equipment is regularly checked and tested consistently and in line with trust policy.
- The trust should continue to ensure that patients are assessed for delirium in line with national guidance.
- The trust should ensure that staff complete Mental Capacity Act training.
- The trust should take steps to improve its staff and public engagement activities.

In critical care:

Diana Princess of Wales Hospital

- The trust should ensure trust policies and best practice guidelines are followed with regards to the management of waste and used linen.
- The trust should consider increasing the level of domestic input on the high dependency unit (HDU) to allow daily cleaning of the floors in patient areas.
- The trust should ensure screening for delirium is undertaken in the HDU.
- The trust should ensure that pressure relieving mattresses are available for patients in HDU when required.
- The trust should encourage and embed the use of patient diaries for patients on ICU.
- The trust should display information to staff, relatives and patients on current safety performance.

Scunthorpe General Hospital

- The trust should consider administrative support for staff on the ICU.
- The trust should review access to mental health support for patients on intensive care.
- The trust should ensure that staff are aware of the transfer bag and are assured that it contains the necessary equipment to support a patient transfer.
- The trust should ensure the most current versions of paper documents are in use in patient records.

Summary of findings

In maternity:

Diana Princess of Wales Hospital

- The trust should make sure all portable electrical equipment is safety tested in line with the manufacturer's guidance.
- The trust should ensure all policies and procedures are in date and reflect national guidance.
- The trust should ensure staff incident report when there are delays in a consultant attending a patient.
- The trust should ensure doctors complete prescription charts and records in line with the hospital and professional guidance.

Goole and District Hospital

- The trust should explore and address reasons for the low use of the birthing suite, and develop and implement a robust vision and strategy to improve utilisation.
- The trust should consider developing a local teenage pregnancy midwife role and expanding the provision of smoking cessation services.

Scunthorpe General Hospital

- The trust should make sure all portable electrical equipment is safety tested in line with the manufacturer's guidance.
- The trust should ensure all policies and procedures should reflect national guidance and in date.

In services for children and young people:

Diana Princess of Wales Hospital

- The trust should ensure that they are meeting the Accessible Information Standards concerning the communication needs of parents/carers.

In end of life care:

Community

- The service should continue to monitor the date of medicines stored in the community hubs and consider implementing a more robust way for all staff to carry medicines to ensure that it is usable in an emergency.
- The service should implement a robust system to regularly check the dates of equipment such as blood sampling bottles.

Scunthorpe General Hospital

- The trust should ensure that patient information is available in formats other than English.

In outpatients:

Trustwide

- The trust should ensure a strategy is developed for outpatients.
- The trust should consider ways to reduce the number of cancelled clinics across outpatients.
- The trust should consider ways to reduce the length of time patients wait for appointments in clinics.

In diagnostic imaging:

Trustwide

Summary of findings

- The trust should encourage clinical audit across all modalities and all sites since clinical audit provides robust evidence of quality.
- The trust should ensure up to date patient information is available and in accessible formats where appropriate.

Diana Princess of Wales Hospital

- The trust should engage further with staff to support recruitment and retention of staff.

Scunthorpe General Hospital

- The trust should engage further with staff regarding recruitment and retention of staff.

Community health services for adults:

- The trust should ensure that when staff transport used sharps bins in vehicles they secure the temporary closure and store the bins in a rigid container as per trust policy.
- The trust should ensure that patient outcomes are monitored, audited and where possible benchmarked to provide evidence of effectiveness and to drive service improvement.
- The trust should ensure that all staff are aware of and use the template to record the information and communication needs of people with a disability or sensory loss in order to meet the accessible information standard.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as inadequate because:

- We did not see evidence that all executive and non-executive directors fully understood the scale of the trust's challenges to finance, quality and sustainability. At this inspection we saw improvements in some of the trust's services but some services had deteriorated since our previous inspection.
- The trust did not have a leadership or talent management strategy and had not taken timely action to develop leaders. The executive team acknowledged there was a significant amount of work to do to establish accountability and effective clinical leadership throughout the organisation.
- The trust had aspirations for the reconfiguration of services with a focus on delivering safe, sustainable services. Leaders described the trust's current strategy as emerging and explained the board was working with the clinical divisions and system partners to develop this.
- Staff morale was mixed; in the 2017 survey results the Trust scored lowest in the country in its response to the question on whether or not staff would recommend working at the Trust. The leadership team recognised the culture in the organisation needed to change and there was evidence of initiatives underway with staff. The Trust had introduced programmes to support ward and divisional managers and in June 2017 launched Listening into Action (LIA), a nationally recognised programme to support organisations to engage with their staff.
- We found some examples of where the board was not fully sighted on some of the risks in the organisation. This did not give us assurance about the flow of information and escalation of risk from 'ward to board.'

Summary of findings

- The trust received a quarterly report from the provider of mental health services. It was not clear who reviewed this information and how the board gained assurance that people's mental health needs were being met.
- A number of the risks we identified at this inspection were ongoing issues that we had found at previous inspections, we spoke with the executive team about how the pace of change in the organisation was not at the rate we would have expected since previous inspections. For example, the trust had been aware of waiting list backlogs since 2015 but did not commence internal clinical reviews until April 2017. In addition, the size of the out-patient follow up waiting list had increased since our previous inspection and previous actions the trust had put in place had not worked in addressing the issue or reducing the risk to patients.
- The trust did not have a financial strategy and the board could not articulate a consistent view of when the trust would achieve financial balance. NHS Improvement reported that the trust had introduced a number of financial grip and control measures, these had an impact on stabilising the finances but there had not been a significant improvement to the monthly deficit rate.
- The trust commissioned a high number of external reviews and we had some concerns about the ability of staff at all levels in the organisation to recognise where and when improvements were required in their own services.
- We found that board members did not have evidence within their personnel file that they had been subject to all the appropriate fit and proper person checks. Therefore, we were not assured that the trust was compliant with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

However:

- Staff talked positively about the changes to the board and felt that the chairman and chief executive were committed to and leading a change in culture. The trust had introduced a pride and respect programme which supported a no tolerance approach to negative behaviours.
- The executive team were working to improve staff and stakeholder engagement recognising that some relationships had been challenging in the past. Following the trust being placed in quality special measures in April 2017 a system improvement board was established led by NHS Improvement which supported the trust to work effectively with partners.
- The trust had an equality and diversity lead and a new equality and diversity strategy in place that included equality objectives for 2018-2022. Overall compliance with equality and diversity training was 93%.
- The trust had reviewed its governance structures and processes as part of the work to improve clinical leadership and accountability in the organisation.
- The chief nurse had introduced accreditation visits to every ward and a number of other clinical areas. The facilities team had created a performance dashboard which included both clinical and non-clinical measures, for example food service and environmental cleanliness.
- The trust had an electronic information system that developed, deployed and supported clinical software applications across primary, secondary and intermediate care. The system provided innovative software designed by clinicians that released time to allow them to deliver quality patient care.
- The trust had appointed a substantive central improvement team incorporating 14 whole time equivalent staff to support the delivery of the Improving Together programme, which was addressing both quality and financial special measures.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↑ Sept 2018	Requires improvement ➔➔ Sept 2018	Good ➔➔ Sept 2018	Requires improvement ➔➔ Sept 2018	Inadequate ➔➔ Sept 2018	Requires improvement ↑ Sept 2018

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diana Princess of Wales Hospital	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement →← Sept 2018
Goole and District Hospital	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Scunthorpe General Hospital	Requires improvement ↑ Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement ↑ Sept 2018
Overall trust	Requires improvement ↑ Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement ↑ Sept 2018

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↑ Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement ↑ Sept 2018
Community	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Overall trust	Requires improvement ↑ Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Inadequate →← Sept 2018	Requires improvement ↑ Sept 2018

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

Ratings for Diana Princess of Wales Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Good → ← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Requires improvement → ← Sept 2018
Medical care (including older people's care)	Requires improvement ↓ Sept 2018	Good → ← Sept 2018	Good → ← Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018
Surgery	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Good → ← Sept 2018	Requires improvement → ← Sept 2018	Inadequate → ← Sept 2018	Requires improvement → ← Sept 2018
Critical care	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Good → ← Sept 2018	Good ↑ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Maternity	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Services for children and young people	Requires improvement → ← Sept 2018	Good ↑ Sept 2018	Good → ← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
End of life care	Requires improvement ↓ Sept 2018	Requires improvement → ← Sept 2018	Good → ← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Outpatients	Requires improvement Sept 2018	Not rated	Good Sept 2018	Inadequate Sept 2018	Inadequate Sept 2018	Inadequate Sept 2018
Diagnostic imaging	Requires improvement Sept 2018	Not rated	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018
Overall*	Requires improvement → ← Sept 2018	Requires improvement → ← Sept 2018	Good → ← Sept 2018	Requires improvement → ← Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement → ← Sept 2018

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

Ratings for Goole and District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Surgery	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018
Maternity	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Outpatients	Requires improvement Sept 2018	Not rated	Good Sept 2018	Inadequate Sept 2018	Inadequate Sept 2018	Inadequate Sept 2018
Diagnostic imaging	Good Sept 2018	Not rated	Not rated	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018
Overall*	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018

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

Ratings for Scunthorpe General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Sept 2018	Requires improvement →← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement ↑ Sept 2018
Medical care (including older people's care)	Requires improvement →← Sept 2018	Good ↑ Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018
Surgery	Requires improvement →← Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Inadequate →← Sept 2018	Requires improvement →← Sept 2018
Critical care	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018
Maternity	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Services for children and young people	Requires improvement →← Sept 2018	Good ↑ Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
End of life care	Requires improvement ↓ Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Outpatients	Requires improvement Sept 2018	Not rated	Good Sept 2018	Inadequate Sept 2018	Inadequate Sept 2018	Inadequate Sept 2018
Diagnostic imaging	Requires improvement Sept 2018	Not rated	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018
Overall*	Requires improvement ↑ Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Requires improvement →← Sept 2018	Requires improvement ↑ Sept 2018	Requires improvement ↑ Sept 2018

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

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Community end of life care	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018
Community dental services	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Overall*	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018

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

Acute health services

Background to acute health services

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of community and hospital-based services to a population of more than 350,000 people across North and North East Lincolnshire and East Riding of Yorkshire.

The trust operates from three hospital sites, Diana, Princess of Wales Hospital, Scunthorpe General Hospital and Goole and District Hospital.

Summary of acute services

Requires improvement 

Our rating of the trust improved. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good.
- Our rating of Diana Prince of Wales Hospital stayed the same. We rated it as requires improvement. We rated two of the hospital's nine services as good, six as requires improvement and one as inadequate.
- Our rating of Goole and District Hospital went down. We rated it as requires improvement. We rated two of the hospital's five services as good, two as requires improvement and one as inadequate.
- Our rating of Scunthorpe General Hospital improved. We rated it as requires improvement. We rated two of the hospital's nine services as good, six as requires improvement and one as inadequate.

However:

- We rated well-led for the trust overall as inadequate. This was not an aggregation of the core service ratings.

Goole & District Hospital

Woodland Road
Goole
Humberside
DN14 6RX
Tel: 01405720720
www.nlg.nhs.uk

Key facts and figures

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

GDH has approximately 44 inpatient beds and 13 day case beds. The hospital provides non-acute medical care, elective surgery, outpatients and diagnostic imaging and midwifery led maternity services. The neuro rehabilitation centre is at GDH, the centre offers specialist services for individuals following severe brain injury and a range of other neurological conditions.

During our inspection of this hospital, we spoke with 34 patients and relatives, 48 staff and we reviewed 42 patient records. We also observed a multidisciplinary team meeting.

Summary of services at Goole & District Hospital

Requires improvement 

Our rating of services went down. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring as good.
- At this inspection we saw improvements in some of the hospital's services but some services had deteriorated since our previous inspection
- We rated three of the hospital's five services as good, one as requires improvement and one as inadequate.
- There was limited evidence that staff had the skills, training and experience to provide the right care and treatment. For example, appraisal rates for a number of staff groups were worse than the trust target and mandatory training rates in four of the five services at the hospital were below the trust target of 85%.
- We found examples in medical care and outpatients where there had not been sufficient effective senior clinical oversight to manage risk and respond to urgent or changing patient needs.
- The total number of patients on outpatient waiting lists had increased since the previous inspection.
- Services at the hospital did not have a vision, strategy or business plan. We saw examples where service delivery did not seem to have been addressed, for example, the delayed discharges in medical care and utilisation of the birthing suite.

Summary of findings

- The hospital did not engage effectively with patients, staff, and the public to plan and manage services.

However:

- Staff cared for patients with care and compassion and respected patients' wishes. Staff provided individualised care and involved patients and those close to them in decisions about their care and treatment
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff felt well-supported by their local leaders and the culture of the hospital was patient-centred.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

Goole and District Hospital is part of Northern Lincolnshire and Goole NHS Foundation Trust providing medical care to people in Goole and the surrounding area. Three sites across the trust provide medical care services; these are Diana, Princess of Wales (DPoW), Scunthorpe General Hospital (SGH) and Goole and District Hospital (GDH). We inspected medical care provided at Goole and District Hospital in two areas: Ward 3 is a 15-bedded ward for patients with general rehabilitation or complex discharge needs, including four dedicated beds for stroke patients and is managed as part of the trust's medical division. We also inspected the Neuro Rehabilitation Centre (NRC) at Goole, a regional specialist centre with 14 beds for integrated inpatient assessment and rehabilitation for people with brain injury and complex neurological conditions. The NRC is managed as part of the trust's community services division.

The trust had 46,603 medical admissions from October 2016 to September 2017. Emergency admissions accounted for 21,155 (45%), 1,040 (2%) were elective, and the remaining 23,408 (50%) were day case.

Admissions to the trust for the top three medical specialties were:

- General medicine – 17,512
- Gastroenterology – 7,290
- Medical oncology – 7,149.

Ward 3 had 39 patient admissions over the past 12 months to April 2017.

The NRC had seen a total of 54 referrals over the past six months since joining the trust (from Sept 2017 to Feb 2018).

We inspected the medical service as part of an announced comprehensive inspection of the whole trust due to it being in special measures. We also made an unannounced visit on 23 May 2018. CQC previously inspected the medical service at this hospital in November 2014 and rated the service 'Good' in all domains. The neuro rehabilitation unit was acquired by the trust in September 2017 and had not been inspected previously.

We visited both wards and observed care being delivered. Before the inspection, we reviewed performance information from, and about the trust.

During the inspection we looked at 18 patient records, spoke with 14 patients and relatives, and 20 staff including doctors, nurses, therapists, care and rehabilitation support workers, ward managers, and student nurses /therapy assistants. We also observed a multidisciplinary team meeting.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- We had some concerns about whether there was sufficient effective senior clinical oversight to manage risk and take appropriate action to respond to urgent or changing patient needs. For example, there had been a serious incident where a patient's anti-seizure medicines had been missed over several days due to difficulties with a naso-gastric tube, the patient had suffered a seizure and needed to be transferred to Scunthorpe hospital.
- Daily checks of resuscitation equipment were not routinely completed and risk assessments and observations were not always reviewed in line with policy.

Medical care (including older people's care)

- We had some concerns about medicines management and pharmacy support. There were no arrangements for pharmacy support on the NRC, which meant there was infrequent medicines reconciliation, medicines were not always available when needed, and we were not assured that nursing staff always recognised and reported medicine incidents. Fridge temperatures were not always checked daily on the NRC and the date of opening of liquid medicines was not always recorded.
- Nursing audits, such as recording of food and fluid intake, omitted medicines and completion of risk assessments had not been carried out on the GDH medical ward or the NRC.
- Staff were not routinely using trust policy and guidance to support patients with on-going need for enteral nutrition (naso-gastric (NG) or percutaneous endoscopic gastrostomy (PEG) feeding). For example, we found gaps in monitoring of nutritional and fluid intake for these patients. A recent serious incident had highlighted a need for training for staff in caring for patients with a nasogastric feeding tube.
- From February 2017 to January 2018 there were 101 reported delayed discharges for GDH. Staff told us these were usually due to waiting for packages of care to be put in place or because of delays with ambulances.
- There was no overarching, fully developed strategy or business plan for the medical service or for community adult services for 2018/2019, although there was a local strategy for the NRC which was part of the community services division. We were not assured that risks on the medical risk register were being actively managed or effectively overseen.
- Although audits had been undertaken for infection prevention and control and timeliness of observations, there was no evidence of audits regarding recording of food and fluid intake and omitted medicines. The observations audit showed very poor compliance. Risk assessments had not been carried out on the GDH medical wards.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so and mandatory training compliance for nursing staff was just below the trust target.
- We observed good infection, prevention and control practice (IPC) in most instances. Environmental and infection prevention and control audits were carried out on both wards and ward 3 took part in quality matron observational audits.
- Incidents were reported; staff were open and honest with patients when things went wrong and managers gave feedback to staff and shared learning from serious incidents.
- Most staff within medicine at GDH had received an appraisal. There was evidence of good multidisciplinary working on both wards to benefit patients and staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff cared for patients with compassion and patient and families' comments were very positive about the calm atmosphere, speed of response and caring approach of staff. Staff worked hard to meet patients' individual needs and supported patients to take part in a variety of activities appropriate to their ability and goals.
- There had been changes to the medical service senior management team and they had clear ideas and early plans for how the services needed to be developed. Staff on both wards told us local leaders were approachable and supportive.

Medical care (including older people's care)

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- We had some concerns about whether there was sufficient effective senior clinical oversight to manage risk and take appropriate action to respond to urgent or changing patient needs. Data showed that observations were not completed in a timely manner on either ward. A recent serious incident had also highlighted the importance of senior clinicians and staff with specialist skills in responding effectively to urgent and changing patient needs on the NRC and across the Goole site.
- Staffing was sometimes a challenge and agency staff were used to mitigate this; however, it was difficult to find agency nurses with the right specialist qualifications, skills, training and experience to support patients on the NRC.
- Daily checks of resuscitation equipment were not routinely completed on the NRC, numbered tags were not used and trolleys were not always promptly restocked after use.
- On the NRC, we saw that some risk assessments were not reviewed weekly, as per trust policy, and re-assessment following a fall was not always completed. We also saw that the care bundle observation chart identified two-hourly checks were required for patients with a tracheostomy and that for one patient several of these checks had been missed or not recorded on several days.
- We had some concerns about medicines management and pharmacy support. There were no arrangements for pharmacy support on the NRC, which meant there was infrequent medicines reconciliation, medicines were not always available when needed, and we were not assured that nursing staff always recognised and reported medicine incidents. Fridge temperatures were not always checked daily on the NRC and the date of opening of liquid medicines was not always recorded.
- There were some issues with the suitability and maintenance of the environment and equipment such as; the therapy kitchen on the NRC had been unavailable for patient use for several months; there were broken doors; and the call bell system was not working effectively at the time of inspection, although plans were in place to resolve these.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Mandatory training compliance for nursing staff was just below the trust target.
- We observed good infection, prevention and control practice (IPC) in most instances. Compliance with the trust wide IPC audits was usually high and above 85%. At Goole, ward 3 scored between 96% and 100% in each recorded audit from April 2017 to April 2018. For the same period, the NRC scored between 77% and 100%. Premises and equipment were mostly clean and tidy.
- Incidents were reported and staff were open and honest with patients when things went wrong and feedback to staff and shared learning from serious incidents was evident. However, we were not assured that all medicines incidents were recognised and reported.

Medical care (including older people's care)

- The nurse staff fill rate was around 95% for this service and, although there were still registered nurse vacancies on the medical wards, the actual numbers of registered staff had gone up from the previous year. Escalation processes were in place to move staff if necessary based on ongoing risk assessments. Ward managers could fill the majority of vacant shifts with bank or agency staff.
- Staff used appropriate tools for identifying deteriorating patients and patients with sepsis. Senior managers had completed a risk assessment to improve arrangements for escalation out of hours and staff were aware of how to obtain support in an emergency.

Is the service effective?

Requires improvement 

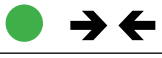
Our rating of effective went down. We rated it as requires improvement because:

- Staff did not routinely use available trust policies and guidance to support patients with ongoing need for enteral nutrition (naso-gastric (NG) or percutaneous endoscopic gastrostomy (PEG) feeding. We found gaps in risk monitoring of nutritional and fluid intake for four of these patients. A recent serious incident had highlighted a need for training for staff in caring for patients with an NG feeding tube.
- There was evidence of specific nursing audits at the trust's other two hospitals, such as recording of food and fluid intake, omitted medicines and completion of risk assessments; however, we were not provided with evidence of these audits for wards at Goole. The NRC did not take part in quality matron observational audits or the nursing dashboard.

However:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Treatment and care pathways were clear and easy to follow and there was evidence of good multidisciplinary working on both wards to benefit patients.
- Although the trust target of 95% was not met, 85% of nursing staff and 93% of support staff within medicine at GDH had received an appraisal between April 2017 to January 2018.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care. We saw evidence of thorough capacity assessments, DoLS applications and best interest decisions which were well-documented.

Is the service caring?

Good 

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

- We observed that staff cared for patients with compassion and patient and families' comments were very positive about the calm atmosphere, speed of response and caring approach of staff. Patients told us there were enough staff to meet their needs and call bells were answered promptly, including at night.

Medical care (including older people's care)

- We observed staff offering patients emotional reassurance when delivering care. Families told us staff explained what was happening to their relatives and provided support to them too as carers. Families told us staff were supportive and understanding if they were not having a good day and gave examples of where staff had advocated for patients regarding funding and other support for families.
- Staff involved patients and those close to them in decisions about their care and treatment. We saw evidence of patient and family involvement in the records we reviewed. For example, we saw evidence of patient-centred goal setting, patients and families contributing to decision-making and conversations with patients and families.
- Data from the NRC patient satisfaction questionnaire March 2017 to March 2018 showed 92% of families and commissioners were likely or extremely likely to recommend the service, 100% patients agreed they were treated with respect by staff and 91% agreed they could speak with a member of the management team if they needed to.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided services in a way that met the needs of local people. The NRC provided a service for people across the region as well as the immediate local population and worked with a variety of CCGs to facilitate this.
- We saw that staff managed challenging behaviour well and made reasonable adjustments to ensure people with a disability received a service on an equal basis with others. Interpreters, communication aids and information in different formats could be arranged, to ensure communication was accessible to patients and their families.
- Staff worked hard to meet patients' individual needs and supported patients to take part in a variety of activities appropriate to their ability and goals. NRC therapies staff conducted home visits and vocational visits with patients e.g. to a person's workplace, to support their rehabilitation. Therapy staff used a person-centred approach and flexed their timetables around patients' physical needs and energy levels.
- The hospital had a low number of complaints, which were responded to in a timely way and staff involved families where possible.

However:

- From February 2017 to January 2018 there were 93 reported delayed discharges for ward 3 at the hospital. These were due to waiting for packages of care to be put in place or because of delays with ambulances.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- The trust was in the process of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the medical service or community adult services for 2018/2019.

Medical care (including older people's care)

- Risks on the risk register were not being actively managed or effectively overseen as many risks had little information in the way of updates indicating that the reviewer was unaware of any progress.
- Although an action plan had been developed to harmonise NRC systems and processes with those of the trust, audit arrangements did not yet mirror those in other parts of the trust. For example, the trust ward assurance dashboard, the full range of nursing audits and the matron observational audit were not used to monitor standards on the NRC.
- Two out of three of the senior leaders of the medical service, the divisional clinical director and the associate chief nurse, were relatively new in post and had not had time to fully develop the services and relationships with staff as they wished. However, they had clear ideas and early plans for how the services needed to be developed.
- The trust acknowledged it had not had sufficient understanding of the NRC unit before it joined the trust to enable effective planning and support. For example, arrangements for pharmacy provision and specialist agency staffing were not in place before the NRC became part of NLaG and these issues had not been resolved at the time of inspection. In addition, the NRC did not initially have a trust matron to report to, which meant there had been delays in establishing the trust requirements for clinical audits, resuscitation equipment checks and safety thermometer reporting.
- The leadership team had not ensured that all nursing staff carrying the emergency bleep had received training regarding expectations and actions to take to lead a site-wide emergency response out of hours.

However:

- Staff on both wards told us local leaders were approachable and supportive.
- Ward managers were planning to work more closely together to ensure their voice was heard by the trust. They reported good support from senior nurses at the trust and medical staff told us they felt supported by the medical director.
- Managers at the NRC described good support from trust directors and the trust chair. There was an allocated non-executive director for the unit and a strategic development board which met monthly.
- The NRC had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and commissioners. Staff were engaged with the local vision and the ethos of the unit.
- Risks for the NRC had been appropriately escalated and logged on the divisional risk register.
- The service engaged with patients, staff, the public and local organisations to plan and manage services.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding Practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Good ➔➔

Key facts and figures

Surgical services at Northern Lincolnshire and Goole NHS Foundation Trust provides elective general, orthopaedic, ophthalmology and emergency surgical care to patients. Surgical services are provided at all three hospital sites, providing 228 beds and 10 high observation beds (HOBs) over 14 wards:

Goole and District Hospital – 14 beds

- Ward 7 (day surgery) – 13 chairs
- Ward 6 – 14 beds

At Goole and District Hospital there are three theatres including one day case theatre. We visited the ward, day surgery unit and the theatres. We spoke with 14 patients and two visitors during our inspection and eight members of staff across the two surgical wards. We observed care and treatment and looked at care records for 16 patients.

We inspected the whole core service and our initial inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. Twelve days later we conducted an unannounced inspection (staff did not know we were coming) to enable us to observe routine activity.

The trust had 43,026 surgical admissions from December 2016 to November 2017. Emergency admissions accounted for 9,415 (21.9%), 3,685 (8.6%) were day case, and the remaining 29,926 (69.6%) were elective.

Surgery at Goole and District Hospital was last inspected in 2014, where all five domains were inspected and an overall rating of good was given

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- There were multidisciplinary team (MDT) meetings held to discuss patients on specific pathways. These meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists.
- The hospital provided timely elective surgical treatments for patients. The service was in the process of increasing the utilisation of Goole and District Hospital for orthopaedic patients.
- Staff felt supported by their managers and colleagues at ward level. Staff enjoyed working for the trust and the directorate.
- From our observations it was apparent that the five steps to safer surgery checklist was embedded as a routine part of the surgical pathway. This was an improvement from our previous inspection.
- The majority of patients we spoke with were complimentary about the care and experience they had received.
- The service had an electronic system in place for reporting, monitoring and learning from incidents. Staff we spoke with could confidently describe how to report incidents.
- We found wards and departments we visited clean and tidy and free from clutter. We saw ward cleanliness scores displayed in public corridors.

However:

Surgery

- The trust must ensure that mandatory training compliance for nursing staff meets their own target.
- We saw variable performance in national audits in the service. The trust was not meeting the national performance standards for treatment or cancer standards.
- Appraisal rates for staff at Goole and District Hospital were worse than the trust target.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- The trust had a fill rate of 96.1% for nursing and midwifery staff in surgery in January 2018. For the past three months, the vacancy level for registered nursing had remained stable at around 9%.
- At the previous inspection, we had highlighted that the five steps to safer surgery including the World Health Organisation (WHO) checklist was not used effectively. During this inspection we saw improved practice and from our examination of 16 patient records it was clear that the checklist was embedded as a routine part of the surgical pathway.
- We saw improvements in the process to identify patients who were deteriorating. We saw that staff had completed records correctly and saw evidence of appropriate escalation.
- We found wards and departments we visited clean, tidy and free from clutter.
- The service had systems in place for reporting, monitoring and learning from incidents. Staff we spoke with could describe confidently how to report incidents.

However:

- We examined 16 patients' records and they were not always complete; for example, consent forms did not always contain signature and job title of health professionals, allergies of patients weren't always recorded, and medication administered was not always signed.

Is the service effective?

Good 

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

- Within surgery, patients had lower than expected risk of readmission for elective admissions when compared to the England averages.
- There were multidisciplinary team (MDT) meetings held to discuss patients on specific pathways. These meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists.
- The wards had access to therapy services over six or seven days a week.
- Staff we spoke with said that there was effective team working in place with colleagues and managers supporting each other to deliver high quality and effective care.
- Staff we spoke with said that they had good access to all information required to deliver services to patients.

Surgery

- The Resident Medical Officer (RMO) was a bleep holder and a communication aid had been ordered for each department.

However:

- Appraisal rates for staff were worse than the trust target. Goole and District Hospital had an appraisal completion rate of 69.4% which did not meet the trust's target of 95%.

Is the service caring?

Good ➔➔

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

- The majority of patients we spoke with described their care in positive terms. Patients told us they felt safe and the nursing staff on the ward were kind and attentive.
- We observed staff treating patients with dignity and respect.
- We saw staff provide emotional support and reassurance to patients.
- The trust had a multi-faith chaplaincy team who could visit patients on the ward to offer spiritual support. Patients could also use the multi-faith prayer room service and bereavement services and had access to specialist nurses for further information and support when required.
- From speaking with patients and their relatives and reviewing care records, we found evidence of their involvement in care planning and delivery.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The hospital provided timely elective surgical treatments for patients. The service was in the process of increasing the utilisation of Goole and District Hospital for orthopaedic patients.
- Staff understood and met the individual needs of patients. We heard examples of how staff supported vulnerable patients including those living with dementia or learning disabilities.
- The trust had a target to close more complex complaints within 60 working days. Of all closed complaints (complex and non-complex) 100% were closed within this target.
- The hospital's performance for elective and non-elective length of stay for surgical patients was better than or similar to the England average.
- In the most recent quarter the number of patients whose operation was cancelled and were not treated within 28 days was better than the England average.

However:

- From November 2016 to October 2017, the average length of stay for all non-elective patients at Goole and District Hospital was 6.5 days, which was higher than the England average of 5 days.

Surgery

- Overall the percentage of cancelled operations at the trust was worse than the England average from January 2016 to December 2017.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Staff we spoke with felt supported by their managers and colleagues at ward level. They felt supported by the matrons and divisional managers as they were visible on the ward and had an open-door policy in their offices, so that staff could approach them at any time with any issues or concerns.
- Staff we spoke with said they felt valued by their patients, ward leaders and the trust and had not witnessed or experienced bullying or harassment.
- The trust was in the process of refreshing its strategy which covered the period 2016-2019. There was no overarching, fully developed strategy or business plan for the surgical service for 2018/2019, however, work was underway to improve the utilisation of Goole District Hospital for elective orthopaedic surgery.

However:

- The directorate did not have a stable management structure in place. The divisional clinical director was new in post and the associate chief operating officer was in an interim role. The associate nurse was the only member of the team that remained in post since the last inspection. This had an impact on the decision making, pace of change, governance and oversight of the issues within surgery.
- The current governance structures were in their infancy within the directorate and required a further period of embedding.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

Maternity services at Goole District Hospital were last inspected in October 2015, where all five domains were inspected and an overall rating of good was given. The safe, effective, caring, responsive and well-led domains were all rated as good.

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

The maternity service at Goole District Hospital is a midwife-led unit and principally serves the East Riding area. There are local three teams of community midwives within the wider Scunthorpe and Goole team. Community midwives work on-call each month, and this can include working in the central delivery suite at Scunthorpe General Hospital.

There is a midwifery-led birthing suite onsite at Goole District Hospital. The birthing suite is located within the grounds of the hospital, with no other inpatient obstetric or neonatal services onsite. The unit therefore supports low risk women who want a birth in a 'home away from home' setting. Those considered high risk are transferred to Scunthorpe General Hospital for delivery.

Community midwives work flexibly across services in the area, offering antenatal and postnatal care in clinics, GP practices, children's centres, and in women's homes.

A weekly obstetric clinic is available for women at Goole District Hospital who meet high risk criteria and need consultant led care closer to home.

During our inspection, we visited the maternity unit and spoke with one patient in clinic, two patients in the community, and four members of staff. These included a matron, midwives, and a student midwife. We observed care and treatment and looked at eight patient records. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of maternity services at Scunthorpe General Hospital, Diana Princess of Wales Hospital and Goole District Hospital.

Summary of this service

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated it as good because:

- The management structure in place had clear lines of responsibility and accountability, and we saw evidence of frequent maternity services meetings and panels, which were appropriately attended.
- Some policies were past their date of review and the trust was aware of this. However, each out of date policy was allocated to a member of staff to review and update within a specific timeframe. A policy review group was also in place. We were assured by the management team that the out-of-date policies would be updated quickly.
- There were protocols in place for the midwifery-led unit and homebirths, which detailed admittance criteria, escalation protocols, pathways for transfer, and actions in the event of emergencies.
- The completion rate for resuscitation training surpassed the trust target, and staff undertook emergency skills and drills training. Staff had recently completed additional 'baby lifeline' training focussed on childbirth emergencies in the community.

Maternity

- We saw systems were in place for reviewing, monitoring, and sharing lessons learned from incidents. We saw evidence of learning from concerns and complaints.
- Safeguarding procedures were in place to refer and safeguard adults and children from abuse, and there was a safeguarding midwife based on site. Safeguarding training completion rates were above or very close to meeting trust targets.
- Equipment, facilities and specialist midwifes were available to meet the needs of patients. A consultant-led obstetric clinic was held in the midwifery-led unit. We observed good team working, with midwives working collaboratively and with respect for each other's roles.
- Outcomes for women were largely positive. The proportion of women who experienced a third or fourth degree tear and large postpartum haemorrhage were within trust targets. The stillbirth rate was also within trust target.
- The women and their relatives we spoke with gave positive feedback about staff and felt they had been supported and included in decision making. Staff were positive about providing good quality and compassionate care to women.

However:

- Nursing and midwifery staff were not up-to-date with their appraisals. They were not meeting the trust compliance target of 95%.
- Nursing and midwifery staff were non-compliant for mandatory training. Completion rates were below the trust target of 85%.
- The community midwife caseloads were non-compliant against national guidance. The level was 143 against the national guidance of 96 cases per WTE midwife.
- There were relatively high proportions of babies born before 37 weeks gestation, and babies born with a low birth weight at term compared to regional averages. The proportion of women smoking at time of booking and at time of delivery was high. At time of inspection, we were not shown any actions in place to address this.
- We saw a decline in the number of women utilising the birthing suite. Only three women had birthed at the unit in the 12 months prior to our inspection. Plans to publicise the service had been ongoing since our last inspection.

Is the service safe?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated safe as good because:

- There were protocols in place for the midwifery-led unit and homebirths, which detailed admittance criteria, escalation protocols, pathways for transfer, and actions in the event of emergencies.
- Women received the appropriate frequency of antenatal appointments and risk assessments. Enhanced assessments and documentation procedures for higher risk women had been established. Staff kept appropriate records of patients' care and treatment.
- The completion rate for resuscitation training surpassed the trust target, and staff undertook emergency skills and drills training. Staff had recently completed additional 'baby lifeline' training focussed on childbirth emergencies in the community.

Maternity

- A safeguarding midwife was based at Goole District Hospital. Safeguarding training completion rates were above or very close to meeting trust targets. Staff could clearly describe safeguarding reporting procedures and felt confident making referrals.
- The safe storage and checking of medicines was taking place in line with policies and procedures.
- There was good cleanliness, infection control and hygiene standards. Areas we inspected were visibly clean and cleaning checklists were fully completed.
- The emergency equipment we inspected was appropriately sealed, the equipment reviewed was in date, and checklists had been completed with few omissions.
- We saw good evidence that systems were in place for reviewing and monitoring, and sharing lessons learned from incidents. Lessons learned were shared at team meetings and in maternity 'patient safety' and 'lesson of the week' circulars.

However:

- Nursing and midwifery staff were non-compliant for mandatory training. Completion rates were below the trust target of 85%.
- The community midwife caseloads were non-compliant against national guidance. The level was 143 against the national guidance of 96 cases per WTE midwife.

Is the service effective?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated effective as good because:

- Some policies were past their date of review and the trust was aware of this. However, each out of date policy was allocated to a member of staff to review and update within a specific timeframe. A policy review group was also in place. We were assured by the management team that the out-of-date policies would be updated quickly.
- Community midwives worked on-call each month and this included working at Scunthorpe General Hospital, and they rotated into the hospital for two weeks every 18 months. This helped them keep up to date with their competencies and skills.
- Facilities were available to meet the nutrition and hydration needs of women and their families, and we saw good evidence of mother and baby health promotion in the areas we visited. A dedicated infant feeding team worked across sites and in the community.
- Outcomes for women were largely positive; the proportion of women who experienced a third or fourth degree tear and large postpartum haemorrhage were within trust targets. The stillbirth rate was also within trust target.
- A specialist bereavement midwife was in post, who worked across sites. There was a new programme of bereavement training with dates offered for May and October 2018.
- Community midwives were trained in postnatal 'check ups' and new-born and infant physical examination (NIPE). The service planned to NIPE train all community midwives to allow women to be discharged from hospital earlier, beginning June 2018.

Maternity

- Staff we spoke with at the midwifery-led unit and in the community clearly articulated the use of Gillick competency for consent of patients under the age of 16 years.
- Midwifery staff in the hospital and community reported good communication, and information sharing between departments and cross-site working within teams.

However:

- Nursing and midwifery staff were not up to date with their appraisals. They were not meeting the trust compliance target of 95%.
- There were relatively high proportions of babies born before 37 weeks gestation, and babies born with a low birth weight at term compared to regional averages. The proportion of women smoking at time of booking and at time of delivery was high. At time of inspection, we were not shown any actions in place to address this.

Is the service caring?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated caring as good because:

- Results from the CQC maternity survey were similar to England averages.
- The women and their relatives we spoke with gave positive feedback, and reported staff were caring and supportive. They felt they had been involved in decision making and had been able to ask questions and express preferences.
- We observed women's health unit staff speaking to patients and their families with respect and understanding. Staff were positive about providing good quality and compassionate care to women.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- There were guidelines and care pathways in place at the trust to support mothers and their family in the event of bereavement. A specialist bereavement midwife was in post, who worked across sites. We saw positive feedback from a family who had experienced bereavement and were cared for by community midwives at the location.
- A multi-faith chaplaincy service was available at Goole District Hospital and outreach support was offered in the community.
- There was a Maternity Voices Partnership in place at the trust with a remit to listen to and take account of the views and experiences of maternity service users. An external provider had undertaken a survey of women who had recently used maternity services, and their recommendations formed the basis of an action plan.

Is the service responsive?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated responsive as good because:

- Services at the midwifery-led unit were planned and delivered to enable women to have flexibility, choice and continuity of care wherever possible.

Maternity

- Women were able to book their initial antenatal appointment directly, by telephone or online, and did not require a referral. The service met the trust target for undertaking antenatal bookings before 13 weeks gestation. Procedures were in place to follow up women who did not attend.
- A consultant-led obstetric clinic was held in the midwifery-led unit. This enabled higher risk women to have antenatal care closer to their home instead of attending clinics at other sites.
- There was a midwifery-led postnatal drop in clinic at the unit, which enabled women who might not otherwise attend to present with any issues or concerns.
- Midwives were available for support and guidance with special interests as part of their role. These included midwives who specialised in safeguarding, teenage pregnancy, smoking cessation, substance abuse, bereavement, and infant feeding.
- A face-to-face and telephone translation service was available. The trust had enabled audio capabilities for their external webpages for those with visual impairments; these also allowed users to listen in a variety of languages.
- From February 2017 to February 2018, only one complaint was identified that related to maternity services at Goole District Hospital. We saw evidence of learning from concerns and complaints raised in the community.

However:

- We saw a decline in the number of women utilising the birthing suite. Only three women had birthed at the unit in the 12 months prior to our inspection.
- There was no teenage pregnancy midwife cover for the location; instead the specialist service had to be accessed at Scunthorpe General Hospital.

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated well-led as good because:

- The management structure in place had clear lines of responsibility and accountability, and we saw evidence of frequent maternity services meetings and panels, which were appropriately attended.
- The trust engaged well with patients, staff, and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. For example, there was a Maternity Voices Partnership, and the Royal College of Gynaecologists had been invited to review and assess maternity services.
- Staff at all levels told us that the interim head of midwifery had had a positive impact on the culture within maternity services at the trust; and she had improved staff engagement and morale. The service had established an 'NLaG Outstanding Midwife' award and had developed local events to celebrate midwifery staff.
- At ward level, staff reported they felt supported by senior managers, they were approachable, and they would feel confident escalating any concerns.
- There were good systems for risk management. A risk management and patient safety strategy were in place, and the maternity services risk register was suitably monitored and updated. Locally, there was appropriate review and monitoring of higher risk women wanting to deliver at the unit or in the community.

Maternity

- We saw good information governance management; actions were in place for policies and guidelines that had expired or were approaching their review date. Staff were familiar with electronic patient record systems, procedures for handling confidential patient information, and using the intranet to access policies and guidance.

However:

- We saw a decline in the number of women utilising the birthing suite. Only three women had birthed at the unit in the 12 months prior to our inspection. Plans to publicise the service had been ongoing since our last inspection, and we did not see evidence of a vision for the service or a robust strategy to improve utilisation.
- The community midwife caseloads were non-compliant against national guidance. The level was 143 against the national guidance of 96 cases per WTE midwife. We saw evidence that some women were unable to deliver at home as planned because of staffing shortfalls. At the time of inspection, community staffing had been identified as an issue on the maternity risk register but had not been added as a separate entry.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Inadequate

Key facts and figures

Outpatients was part of the clinical support services directorate. Pathology was provided by a service managed by the trust and provided services to other trusts. A range of clinics were provided by outpatients such as surgery outpatients, medicine outpatients, ophthalmology, respiratory, diabetes, urology, neurology and ear, nose and throat.

Outpatient services were provided on all three hospital sites in dedicated outpatient areas. The majority of clinics were provided during core hours; however, a small number of evening and weekend clinics took place. Waiting lists for each speciality were held and managed by that speciality.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. The inspection was part of a comprehensive inspection. We visited Goole and District Hospital outpatients, Scunthorpe Hospital outpatients and Diana, Princess of Wales Hospital outpatients at the trust during the inspection. We inspected outpatients as part of this inspection as outpatients at the previous inspection was rated as inadequate and we found a number of concerns within the service.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

During this inspection we visited general outpatients and ophthalmology outpatients at Goole and District Hospital.

Between November 2016 and October 2017 there were 34,481 outpatient appointments at Goole and District hospital.

We spoke with one patient and eleven staff during our inspection.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated the service as inadequate because:

- There were 31,295 patients overdue their follow up appointment as at March 2018. This was worse than the previous inspection.
- The trust had started to clinically validate and administratively validate some waiting lists; however, this was not complete for all patients across all waiting lists.
- Referral to treatment indicators were not met across all specialities. This had not improved since the previous inspection.
- There were 320 patients waiting over 52 weeks at the trust as at March 2018. This was worse than the previous inspection.
- The trust was performing worse than the 85% operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral.
- The ‘did not attend’ rate for Goole & District Hospital (Acute) was higher than the England average.

Outpatients

- There was no formal strategy for outpatients at the trust and staff were not always aware of the trust vision and values.

However:

- Nurse staffing levels were generally as planned in outpatients.
- Staff had access to trust policies and audits that were relevant to outpatients were completed within specialities.
- Staff were friendly and provided compassionate care to patients and ensured privacy and dignity was maintained.
- Patient feedback regarding services was generally positive.
- Staff told us morale was generally good across the services.

Is the service safe?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated safe as requires improvement because:

- The previous inspection found that clinical validation and assessment of risk within waiting lists had been slow to be implemented across all specialities. The trust had started to clinically validate some waiting lists; however, this was inconsistent and not complete across waiting lists in all specialities.
- At this inspection clinical validation in terms of clinical harm reviews had been commenced but not been completed across all specialities. Clinical validation was only being completed on patients on waiting lists where they were six months overdue their appointment date; waiting more than 40 weeks for treatment; and confirmed cancer patients waiting over 104 days for treatment. This did not provide assurance that there was clear oversight of the risk posed to patients on waiting lists.
- The trust declared a serious incident in May 2018 that related to a delay in a patient receiving treatment. This was found during a validation exercise.
- The clinical harm review of the patients overdue six months or more for their appointment was ongoing, however was not yet complete at the time of our inspection. The clinical harm group had identified patients who had died whilst waiting for a follow up appointment; however there had been no formal reviews of these deaths to see whether the delay in appointments or treatment may have contributed to the patient deaths.
- The total number of patients on waiting lists had increased since the previous inspection.
- Nursing staff at Goole District Hospital failed to meet six out of the ten training modules for the trust target for mandatory training.

However:

- All areas we visited were visibly clean and tidy.
- Nursing staffing levels were as planned in outpatients.
- Medicines were stored securely in the areas visited.

Outpatients

- Staff we spoke with were aware of reporting incidents and using the incident reporting system and were aware of the duty of candour.

Is the service effective?

Not sufficient evidence to rate

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We did not rate effective.

However:

- Staff had access to a trust intranet which contained the trust policies and procedures available to staff.
- Audit was generally carried out within the specialities that provided outpatients. A number of clinics we visited told us they completed annual audits.
- Staff in outpatients told us they were able to provide drinks to patients who had waited a long time or who required a drink.
- From November 2016 to October 2017, the follow-up to new rate for Goole and District Hospital was similar to the England average.
- Staff had received annual appraisals and staff we spoke with had generally had opportunity to develop and complete further training.

Is the service caring?

Good

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated caring as good because:

- We observed staff of all grades interacting with patients. Staff introduced themselves, were friendly and welcoming and were quick to offer help when required.
- Overall, patient feedback was positive and staff were described as being caring, patients felt supported and treated with dignity and respect. Experience data was displayed and feedback on a patient satisfaction board was mostly positive.
- Clinical nurse specialists were available in a number of clinics to provide further support to patients. Staff were able to direct patients to a range of appropriate support services.
- Chaperones were available where required in clinics.

Is the service responsive?

Inadequate

Outpatients

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated responsive as inadequate because:

- The previous inspection found issues with referral to treatment indicators. During this inspection we found that referral to treatment indicators were not met across all specialities. There was no clear plan for recovery or a trajectory to improve referral to treatment performance.
- The previous inspection found concerns with the number of patients overdue their appointment. During this inspection we found there were 31,295 patients overdue their follow up appointment as at March 2018. This was worse than the previous inspection. During this inspection we found there were still patients without an appointment due date.
- From November 2016 to October 2017, the 'did not attend' rate for Goole and District Hospital was higher than the England average.
- There were 320 patients waiting over 52 weeks for an outpatient appointment at the trust as at March 2018. There was no clear plan for recovery or a trajectory to improve the 52 week wait performance.
- The trust was performing worse than the 85% operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral. There was no clear plan for recovery or a trajectory to improve the 62 day cancer pathway performance.
- The April 2017 to April 2018 outpatient key performance indicator dashboard showed the outpatients booked slot utilisation rate was below the trust target of 95%. In April 2018 at Goole and District Hospital it was 86.7%.

However:

- The trust was performing 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).
- Senior managers we spoke with told us they met regularly with the clinical commissioning groups regarding service delivery and attended regular business meetings for outpatients.
- Outpatient clinics had various patient information leaflets they could provide to patients and translation services were available in outpatients.
- The trust had introduced a lead for patient administration and access to address the concerns raised at the previous inspection.

Is the service well-led?

Inadequate

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated well led as inadequate because:

- Since the introduction of a patient administration and access lead for outpatients, areas such as booking appointments and staff training on referral to treatment standards had improved; however, the pace of work and increasing waiting lists remained a significant concern.
- Staff we spoke with at all levels in the trust were not always clear on the actual number of patients on waiting lists.

Outpatients

- Concerns and challenges around referral to treatment indicators and the number of patients overdue their follow up appointments had not been fully addressed at this inspection. The trust was working on addressing the issues; however, the overdue follow up patient backlog had increased since our last inspection. There was no clear improvement trajectory for the 31,295 patient follow up backlog.
- There had been an increase in patients waiting over 52 weeks for an appointment and no clear plan to address concerns regarding this or the 62 day operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral.
- At the time of the inspection the trust did not have an effective performance management framework in place. Work had begun to encourage ownership of performance in the divisions.
- There was no formal strategy for outpatients at the trust.

However:

- There was a management structure for outpatients and governance systems were in place. Risks were documented on risk registers which were reviewed monthly.
- Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available for support when required. Morale was generally good in outpatients and staff felt supported.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diagnostic imaging

Good

Key facts and figures

Diagnostics and radiology were part of the clinical support services directorate. There was one diagnostic imaging department at Goole District Hospital where plain film x-rays were carried out.

The department supported an external provider who carried out MRI and CT scans by providing consumables and an emergency box. The patients were all trust patients, however staff and equipment were supplied by the external provider.

Radiology services were provided on all three hospital sites in dedicated diagnostic imaging suites. The department was open Monday to Friday 8am until 5.30pm, Saturday and Sunday until all patients had been seen.

Clinical Support Services' role was to provide radiography and nursing staff, administration support for receptions and all of the health records functionality. Waiting lists for each modality were managed by that modality.

During the inspection we visited the diagnostic and radiology department and the changing rooms used by the external provider for trust patients. We spoke with five staff but no patients on this inspection.

Summary of this service

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as good at this inspection because:

- Patients were safe and there were processes in place to ensure they were not overexposed to radiation.
- The service had sufficient staff, who had completed mandatory training to support patients' needs.
- The department was clean and tidy. Equipment was maintained and in working order. Breakdowns were repaired quickly.
- The department at GDH was effective. Patients were seen quickly on arrival and there were facilities to meet their individual needs.
- Staff had access to policies and procedures based on best practice.
- Staff were aware of their responsibilities relating to consent, mental capacity and safeguarding of vulnerable people.
- Performance against national and local standards, targets and performance indicators was closely monitored. Waiting times for urgent patient pathways were being met at GDH.
- Staff felt well supported locally by their manager and colleagues and the culture of the department was patient centred. The wider trust had started to engage with staff although this was a work in progress.

However:

- Medical staffing was low across the trust with significant vacancies and those medical staff in place were not up-to-date with mandatory training.
- At the time of the inspection we did not see evidence that the department was participating in local clinical audit, therefore we were not assured policies and procedures were being adhered to. However, after the initial report was written, the trust sent us evidence to show some clinical audit was being carried out by radiologists.

Diagnostic imaging

- Once treated, patients had long waits to receive the results of their tests. This was a trust-wide problem compounded by low medical staffing numbers.

Is the service safe?

Good

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings. We rated safe as good because:

- Radiography staff who worked at Goole District Hospital (GDH) met or exceeded the trust's 85% completion target for all mandatory training modules except Prevent training. Radiography staff at GDH met or exceeded the trust's 85% completion target for all safeguarding training modules.
- All areas we visited were visibly clean and tidy. We saw department staff participate in hand hygiene activities and we observed equipment being cleaned.
- Staff were aware of the risks associated with working with radioactive substances and followed safety guidance to protect themselves and their patients
- Managers told us there were no current concerns with radiographer staffing numbers at GDH as this was only a small team. Extra staff could be accessed from other sites in the trust to cover absences when required.
- There were limited supplies of medicines used in the department, however these were stored appropriately and securely.
- Equipment was maintained in line with manufacturer requirements and was in working order.
- From January 2017 to December 2017, the trust reported no incidents classified as never events and no serious incidents for diagnostics and radiology.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.

However:

- Medical staff who worked across the trust did not meet the target for adult safeguarding training, prevent training, resuscitation training, information governance and slips, trips and falls training.
- There were trust-wide shortages of radiologists. This impacted on reporting rates across the trust, including GDH.
- The process for escalation of adverse scan results was not as robust as it should be and there was a potential for patients to suffer harm as a result.

Is the service effective?

Not sufficient evidence to rate

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings. We did not rate effective.

However:

- Staff in radiology told us they could provide drinks to patients who had waited a long time or who required a drink. Light snacks were also available for patients who had medical conditions.

Diagnostic imaging

- The department had limited opening hours; however, these were targeted to when demand was at its highest. There were alternative facilities available for patients outside of opening hours at GDH at the other hospital sites within the trust.
- The department had competent staff in post and a local induction for new or temporary staff working in the department.
- There was some information in the department about health promotion, such as diet and stopping smoking.
- Patient outcomes were discussed, and radiographer performance was monitored and managed to ensure good quality x-rays and scans were produced. Multidisciplinary working took place with specialties to review scans and x-rays for patients with complex conditions.
- Staff had access to a trust intranet which contained the trust policies and procedures available to staff.
- Staff were aware of their responsibilities in relation to the Mental Capacity Act and obtaining consent from patients and had received training in supporting patients living with dementia.
- At the time of the inspection we did not see evidence that the department was participating in local clinical audit, therefore we were not assured policies and procedures were being adhered to. However, after the initial report was written, the trust sent us evidence to show some clinical audit was being carried out by radiologists.
- Health promotion was limited other than when patients requested information or when staff deemed patients to be at risk of potential harm.
- The department was not meeting the 95% target for staff appraisals.
- Staff we spoke with generally had opportunity to develop and complete further training.

Is the service caring?

Not sufficient evidence to rate

We were unable to rate this domain as there were no patients in the department at the time of the inspection.

Is the service responsive?

Requires improvement

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings. We rated responsive as requires improvement because:

- Patients had long waits to have their x-rays and scans reported, which caused delays in reports being sent to patients' GPs and potential delays to patients receiving treatment.
- Information leaflets were not available in the department for patients requiring an accessible format such as easy read or braille. Of the information leaflets available, seven were overdue for review.

However:

- There were processes in place to monitor performance against national and trust targets. These were scrutinised regularly and validated to ensure the most urgent patients were prioritised.

Diagnostic imaging

- GDH was meeting performance targets for access to ultrasound and plain film x-rays for 31 and 62-day wait patients. These were the two modalities performed on the GDH site.
- Did not attend rates were low.
- There had been no complaints about diagnostics and radiology and GDH.

Is the service well-led?

Good

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings. We rated well led as good because:

- Staff at GDH told us they were well managed locally and had confidence in their line manager to address any concerns they had in a fair and timely manner.
- There was a supportive culture at GDH and staff had excellent interpersonal relationships with their colleagues of all disciplines.
- There were governance processes in place across the whole of clinical support services. Staff were aware of and engaged in the process.
- The trust had a risk register that was updated regularly, however there were no risks identified specifically for radiology at GDH. This correlated with what we saw when we inspected. Delays in reporting and staffing numbers were reported as a trust wide risk.
- There was regular data collection and information management was a key part of the management processes within the directorate, including GDH. Data was used effectively to performance manage the department.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diana Princess of Wales Hospital

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www.nlg.nhs.uk

Key facts and figures

Diana Princess of Wales Hospital (DPoW) is one of the three hospital sites for Northern Lincolnshire and Goole NHS Foundation Trust. It is located in Grimsby and provides acute hospital services to the local population.

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

DPoW has approximately 342 inpatient beds, 54 day case beds and 16 children's beds. In addition, the hospital provides critical care services, with eight beds available for intensive care and high dependency, close to the main theatre complex.

During our inspection of this hospital, we spoke with 135 patients and relatives, 367 staff, reviewed 180 patient records and 64 medicine charts. We observed a medical handover.

Summary of services at Diana Princess of Wales Hospital

Requires improvement

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well led as requires improvement and caring and as good.
- At this inspection we saw improvements in some of the hospital's services, but some services had deteriorated since our previous inspection.
- We rated two of the hospital's nine services as good, six as requires improvement and one as inadequate.
- The hospital did not always have appropriate numbers of staff to ensure patients received safe care and treatment. The trust had introduced some additional staff and roles and used agency staff to provide cover and mitigate some of the risk to patients.
- There was limited evidence that services staff had the skills, training and experience to provide the right care and treatment. For example, appraisal rates for a number of staff groups were worse than the trust target and mandatory training rates in eight of the nine services at the hospital were below the trust target of 85%.
- Services at the hospital did not all manage medicines in line with trust policy or national and professional guidance.

Summary of findings

- Not all services provided care and treatment based on national guidance. There was variable participation and outcomes in local audit and national audit and we found action plans did not always address the effectiveness of the care and treatment patients received.
- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Training compliance in relation to the Mental Capacity Act did not meet the trust target in some services.
- People could not always access services when they needed it. The total number of patients on outpatient waiting lists had increased since the previous inspection. Delayed transfers of care, outlying patients, bed moves at night remained a concern in medical care.
- Services did not always manage and investigate concerns and complaints in line with the trust's policy.
- We had some concerns about the ability of staff at all levels in the hospital to recognise where and when improvements were required in their own services.
- Services at the hospital did not all have a vision, strategy or business plan. There was limited evidence of effective engagement with patients, staff, and the public to plan and manage services.

However:

- The trust had acted on most of the concerns in the Section 29A warning notice that was issued after the inspection in November 2016.
- Staff used appropriate tools for identifying deteriorating patients and patients with sepsis and audits showed good compliance with these tools and escalation processes. Nurses told us that medical response to patients they escalated was prompt.
- Staff worked together as a team to benefit patients. Doctors, nurses, porters, other healthcare professionals and non-clinical staff supported each other to provide good care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment.
- Staff morale appeared to be improving and most staff reported feeling well-supported by their immediate line managers.

Urgent and emergency services

Requires improvement 

Key facts and figures

Diana Princess of Wales (DPoW) Hospital has one accident and emergency department (also known as A&E, emergency department or ED). The emergency department at DPoW hospital is a category one and recognised trauma unit providing 24-hour, seven-day a week service to the local population.

There were 151,765 attendances from April 2016 to March 2017 at Northern Lincolnshire and Goole NHS Foundation Trust as indicated in the chart above. This included patients who attended Goole minor injury unit. Services at the minor injuries centre at Goole was provided by the trust until April 2018.

From October 2016 to April 2017 the department at DPoW had 38,301 attendances at its Urgent and Emergency Care department, an average of 179 patients attending per day. The number of patients attending aged under 16 from April 2017 to March 2018 was 12,160 attendances. The percentage of A&E attendances at this trust that resulted in an admission remained similar from 2015/16 to 2016/17 and was slightly lower than the England average.

Patients that attended the department were triaged to identify where best to be treated. At the front of the department there was a nurse sat with the reception staff to identify where the patients' needs would be best met. Patients would be triaged to either remain in the department or referred to the GP in the department or discharged.

The department was split into several different areas; these included resuscitation, minors, majors and ambulance assessment area. There were four resuscitation bays to be used for patients' with more complex and urgent health needs. Two of these bays were equipped for more specific and individual needs including paediatric and major trauma. Minors had eight treatment rooms including two rooms for specialised treatments such as ear, nose and throat and a small plaster room. There were 13 major cubicles with four identified as high observation bays across from the nursing and medical station for visibility. One of the cubicles was a designated mental health room with two door access. One of the cubicles could be used for isolation purpose in the outbreak of an infectious disease.

There was a dedicated ambulance entrance for patients arriving by ambulance. There were four ambulance assessment cubicles where patients were assessed before to moving to other parts of the department.

We inspected all areas of the department and spoke with 33 members of staff and 14 patients and relatives. We observed daily practice and viewed a variety of information in 49 sets of records. We held staff focus groups and reviewed trust policies and performance information from, and about, the trust.

At the last inspection in November 2016, ED was rated overall as requires improvement. Safe, effective, responsive and well-led were rated as requires improvement. Caring domain was rated as good. Following the inspection we issued the trust with a Section 29A warning notice which stated that the quality of health care provided by the trust required significant improvement specifically in ED and one other service.

There were significant issues relating to ED:

- Staff shortages and a lack of escalation processes about the shortages and putting patients at risk.
- The lack of patient assessments and / or escalation of patients identified as being at risk causing patients' safety to be compromised.
- There was insufficient management oversight and governance of the identified risks.

Urgent and emergency services

We undertook an unannounced visit in June 2017 to follow up on the actions the trust told us they had taken in relation to the Section 29A warning notice issued in January 2017. We found that the trust had not taken sufficient, timely action to address all our concerns.

Our inspection in May 2018 was announced (staff knew we were coming).

Summary of this service

Our rating of this service stayed the same although we saw some improvements. We rated it as requires improvement because:

- The number of registered sick children's nurses (RSCN) had reduced and the department did not have enough to provide cover on each shift. Three staff had completed university accredited modules in paediatric care out of 71 staff. None of the emergency nurse practitioners (ENP) had completed any paediatric modules or courses. Paediatric and adult patients were cared for in the same areas and used the same facilities. A children's waiting area could be used for only part of the day when the paediatric assessment unit was open.
- The majority of mandatory training figures for both medical and nursing staff did not meet the trust's target of 85%. Medical staff did not meet any of the ten mandatory training courses and nursing staff only met two out of ten mandatory training courses. For safeguarding training, four out of eight training figures met the trust target.
- There were vacancies for medical staffing which meant that locums covered many shifts, however some gaps were left unfilled.
- Medicines were not stored appropriately when required to be refrigerated and no mechanism was in place for monitoring out of range temperatures.
- The designated mental health room was not ligature free.
- Some patient pathways had not been reviewed and remained out of date, these included pathways that we raised at our inspection in November 2016. Patient group directions (PGD) that were due to be reviewed in 2017 had been extended to August 2018 before they would be reviewed.
- Appraisal rates were not met for any of the staff groups.
- Royal College of Emergency Medicine (RCEM) audits showed that the trust failed to meet the 100% national standard set. We reviewed six RCEM audits and found out of 32 standards: - the trust was in the lower UK quartile for six standards.
- Mental capacity was not always recorded in patient records we reviewed. Out of 21 records, 15 had completed information about mental capacity. We saw that two patients who were living with dementia did not have their mental capacity recorded. The trust's unplanned re-attendance rate to A&E within seven days was between 9% and 10% and consistently worse than the national standard of 5% average in 11 out of 12 months.
- Further work was required to embed strategies that would improve flow. These included adhering to the ED escalation process, introduction of frailty assessment team (FEAST) and improving ambulatory care.
- There was no consistent method in reporting patients that had left the department without being seen.
- Senior managers had identified that the trust needed to work more cohesively with other specialities and external providers to support ED staff and reduce the length of stay for patients, but the pace of arranging and changing practice was not embedded.

Urgent and emergency services

- The trust was not meeting their targets to close complaints within the allocated timeframes. For example, 30% were closed within 30 days and 50% within 45 days. For complex complaints, 80% were closed within the time frame of 60 days.

However:

- The trust had acted on the concerns and Section 29A warning notice that was issued after the inspection in November 2016. This included changes and improvements to patients' record keeping. Risk assessments had been completed and monthly dashboards were completed to provide assurances that these were completed. There had been an increase in healthcare assistants to provide regular care rounds to patients to support them with their needs.
- There were improvements in how patients were provided with nutrition and hydration and pain relief. A monthly dashboard provided the department with assurances that patients' needs were being met.
- There were improvements to the time patients waited from arrival to their initial assessment with the introduction with the department streaming and triaging patients. This had reduced from 30 minutes to 15 minutes to be assessed. There had also been a reduction with turnaround times over 30 minutes, since July 2017, for ambulance journeys.
- We reviewed six RCEM audits and found out of 31 standards, the trust was in the upper UK quartile for six standards. The trust was similar to other hospitals (between upper and lower UK quartiles) for 20 standards
- We observed that wards had effective approaches to multidisciplinary working. Staff described good working relationships between consultants, nurses and allied health professional staff.
- Patients provided feedback and told us that staff were caring and provided compassionate care. They felt involved in making decisions with their care and treatment. Privacy and dignity was observed and patients were supported with the emotional needs.
- The trust had applied measures to manage the access and flow in the department. These included regular meetings and escalation processes to support the department. There had been an introduction of streaming and triage staff that triaged patients. There had been reductions in the time to treat and patients waiting from the decision to admit until being admitted. There were improvements towards the four-hour target which was better than the England average from October 2017 to January 2018.
- The department had invested in increasing the numbers of staff within leadership roles to provide an overview and to monitor and review ongoing care in the department. Various mechanisms had been implemented to provide assurances that there was an oversight of the issues in the department. These included walk rounds, board rounds, safety huddles and quality meetings.
- The majority of staff enjoyed working in the department and felt listened to. The local leadership in the department was evident and had identified risks such as the lack of registered sick children's nurses and had plans in place to mitigate the risk. These included further training and extended paediatric resuscitation skills. Staff within the department had initiatives to support and celebrate the success of their colleagues. The department was also working with vulnerable patient groups to improve the patients' experience.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same although we saw some improvements. We rated it as requires improvement because:

Urgent and emergency services

- The number of registered sick children's nurses (RSCN) had reduced and the department did not have enough to provide cover on each shift. This did not meet the standards set in the Intercollegiate Emergency Standards 2012. There was no separate paediatric department and children used the same facilities as adult patients. There was a small children's area in the same area which was for children accessing the paediatric assessment unit that children could utilise. However, this area was not accessible at all times.
- There were several medical vacancies which as a result left gaps within the rotas. Some of these gaps were covered by locum staff. There was not consistent cover by the consultants between the agreed hours of 8am to 10pm. This did not meet the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day.
- Mandatory training figures did not meet the trust's target of 85% for any of the courses for medical staff. There were ten mandatory courses for medical staff, the highest compliance rate was 64% for four courses including resuscitation. The lowest compliance rate was 29% for fire safety. Two out of four courses were met for safeguarding courses with the lower two compliance rates achieving 67% and 79%.
- Mandatory training figures did not meet the trust's target of 85% for eight out of ten courses for nursing staff. Four courses had a compliance rate between 70% and 84%, two courses at 64% and one course at 51%. The lowest compliance rate was 42% for fire safety. The trust's target was met for both resuscitation and equality and diversity. Two out of four courses were met for safeguarding courses with the lower two compliance rates achieving 70% and 84%.
- There were some vacancies for registered nurses which had impacted on the ability to cover the shifts with the required amount. Many shifts were covered through bank and agency staff.
- There was a lack of processes in place for the medicines fridge.
- The designated mental health room was not ligature free; however, the trust did respond promptly to the removal of two ligature risks.

However:

- The trust had improved record keeping. The patient records had been reconfigured and we saw improvements where risk assessments including care rounds and National Early Warning Score (NEWS) scores were recorded. Mental Health risk assessments were completed which reviewed a patient's risk level and actions required.
- Staff were aware of how to refer to safeguarding and discussed circumstances when this occurred.
- The introduction of the streaming nurse had improved and reduced the time from arrival to initial assessment. This had improved from 30 minutes down to 15 minutes, although the median time was 15 minutes in comparison to the England average of nine minutes. There had also been a reduction with the amount of ambulance journeys with a turnaround time of over 30 minutes since July 2017.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- Some patient pathways had not been reviewed and updated that were identified at our previous inspection in November 2016. The patient group directions (PGD) that staff used to administer medicines were due to be reviewed in 2017, however they had been extended to August 2018 before they would be reviewed.

- Appraisal rates identified that they were not meeting the trust's target of 95%. Reports identified that 90% medical staff, 79% support staff and 56% of nursing staff received an appraisal.
- Royal College of Emergency Medicine (RCEM) audits showed that the trust failed to meet the 100% national standard set.
- We reviewed six RCEM audits and found out of 32 standards: the trust was in the lower UK quartile for six standards.
- In the consultant sign off audit the hospital was worse than other hospitals (lower UK quartile) for three standards and similar to other hospitals (between upper and lower UK quartiles) for one standard.
- Three staff had completed university accredited modules in paediatric care out of 71 staff. None of the emergency nurse practitioners (ENP) had completed any paediatric modules or courses.
- Mental capacity was not always recorded in patient records we reviewed. Out of 21 records, 15 had completed information about mental capacity. We saw that two patients who were living with dementia did not have their mental capacity recorded.
- The trust's unplanned re-attendance rate to A&E within seven days was between 9% and 10% and consistently worse than the national standard of 5% average in 11 out of 12 months.

However:

- We reviewed six RCEM audits and found out of 31 standards: the trust was in the upper UK quartile for six standards, the trust was similar to other hospitals (between upper and lower UK quartiles) for 20 standards.
- In the moderate and acute severe asthma RCEM audit the hospital was better than other hospitals (upper UK quartile) in three standards and similar to other hospitals (between upper and lower UK quartiles) for four standards.
- Care was provided based on evidence-based practice and national guidance. New staff to the department were well supported, including providing protected time to develop competencies which ensured they could care for patients effectively.
- Improvements were noted in how patients were provided with nutrition and hydration. It was recorded when patients were offered food and drink in a care round provided by staff. Patients and relatives were able to access hydration stations and were provided with warm meals when patients had been in the department for a period of time.
- The trust had implemented new mechanisms to review whether patients' pain scores had been completed and reviewed. Monthly audits of these were completed in the department and cascaded to staff. The trust's scores showed that mostly patients' pain scores were completed. Further work was required to improve the percentages for reviewing the pain relief given.
- We observed that wards had effective approaches to multidisciplinary working. Staff described good working relationships between consultants, nurses and allied health professional staff.

Is the service caring?

Good ➔➔

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

- Patients told us that they received compassionate care and that staff supported their emotional needs. Patients provided us with positive feedback about their care during our inspection. Privacy and dignity was maintained.
- Patients' wishes were respected and staff provided individualised care.

Urgent and emergency services

- Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives, we spoke with told us they felt well informed by doctors and nursing staff about their condition, treatment options and plan of care.
- Patients were provided with emotional support from staff to minimise their distress. Patient felt reassured.

However:

- Results from the Friends and Family Test were slightly worse than the England average although there had been some improvement seen in score since August 2017.

Is the service responsive?

Good ↑

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

- Services were planned and provided in a way that met the needs of local people. They worked with commissioners, external providers and local authorities to improve the patient's pathway and experience.
- Patients' individual needs were met. Systems were in place for patients living with dementia and learning difficulties to support them through their hospital stay.
- The trust had applied measures to manage the access and flow in the department. The introduction of streaming and triage staff had ensured that patients were seen in the relevant areas by the most appropriate clinician. We saw that there had been reductions in the time to treat and patients waiting from the decision to admit, until being admitted. There were improvements towards the four-hour target which was better than the England average from October 2017 to January 2018.
- Regular operational meetings were held to understand the bed situation, enable planning for expected admissions and discharge and to ensure patient flow throughout the hospital was timely. There was an escalation policy in place which allowed medical staff to make autonomous decisions in managing patient capacity within the department. This included emergency department consultants admitting patients to speciality areas.
- Patients knew how to complain and staff knew how to deal with complaints they received. Complaints were investigated and learning was shared with staff.

However:

- Further work was required to embed strategies that would improve flow. These included adhering to the ED escalation process, introduction of frailty assessment team (FEAST) and improving ambulatory care.
- The trust was not meeting their targets to close complaints within the allocated timeframes. For example, 30% were closed within 30 days and 50% within 45 days. For complex complaints, 80% were closed within the time frame of 60 days.
- There was no consistent method in reporting patients that had left the department without being seen.

Is the service well-led?

Good ↑

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

Urgent and emergency services

- The trust had acted on the concerns and Section 29A warning notice that was issued after the inspection in November 2016. In particular the lack of patients' risk assessments and escalation of patients at risk.
- The department had invested in increasing the numbers of staff within leadership roles and a shift lead was in charge to monitor and review ongoing care in the department. Various mechanisms had been implemented to provide assurances that there was an oversight of the issues in the department. These included walk rounds, board rounds, safety huddles and quality meetings.
- The risk register identified that there remained issues with staff shortages particularly with medical staff. Systems had been put in place to review staffing on a daily basis and the implementation of new roles to support the team.
- The majority of staff enjoyed working in the department and felt listened to. Senior management spoke positively about their staff and felt proud of their team. Staff supported each other and worked well together. Staff within the department completed initiatives to support and celebrate the success of their colleagues. The trust had invested in staff to complete extra training to advance in their careers.
- The department was interacting with specific patient groups to identify and improve patients' experiences and interactions with staff.
- Information technology systems were in place to monitor and improve the quality of care. These included the use of a monthly ED dashboard to review and monitor nursing care records and the live ED system that allowed up to date information on the current demands of the department.

However:

- Senior managers had identified that the trust needed to work more cohesively with other specialities and external providers to support ED staff and reduce the length of stay for patients, but the pace of arranging and changing practice was not embedded.
- The risk register did not highlight that they were not meeting the national requirements for registered sick children's nurses. However, the local leadership in the department were aware of the risk and supported staff to complete further training and extended paediatric resuscitation skills to mitigate the risk.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

Diana, Princess of Wales Hospital is part of Northern Lincolnshire and Goole NHS Foundation Trust providing medical care to people in Grimsby and the surrounding area. Three sites across the trust provide medical care services, these are Diana, Princess of Wales (DPoW), Scunthorpe General Hospital and Goole and District Hospital. Diana, Princess of Wales provides medical care in eight medical wards, and covers a number of different specialties, including general medicine, care of the elderly, respiratory medicine, diabetes/endocrinology, gastroenterology, neurology and stroke care. There are 195 beds located within eight wards.

The trust had 46,141 medical admissions from December 2016 to November 2017. Emergency admissions accounted for 21,578 (46.7%), 675 (1.5%) were elective, and the remaining 23,888 (51.8%) were day case.

Admissions for the top three medical specialties were:

- General medicine – 18,033
- Gastroenterology – 7,229
- Medical oncology – 7,008

The medical wards at DPoW specialise in certain conditions, which are:

- Amethyst Unit - haematology and oncology.
- Coronary Care Unit (CCU) - cardiology
- C1 Kendall - cardiology
- C1 Holles – general medicine
- C5 - respiratory medicine
- C6 - gastroenterology
- Stroke unit – acute stroke and rehabilitation
- Acute Medical Unit (AMU) acute general medicine

The acute medical unit (AMU) has 39 beds split into two parts; assessment and short stay. The unit provides an area for intensive work to stabilise patients for transfer to another medical ward or to facilitate discharge home within 24 hours of admission. There is also an ambulatory care unit.

The hospital has an endoscopy unit and a discharge lounge on site that were included as part of the medical service inspection.

We inspected the medical service 8-11 May 2018 as part of an announced comprehensive inspection of the whole trust due to it being in special measures. CQC previously inspected the medical service at this hospital in October 2016 and rated the service as 'requires improvement' overall, with 'good' for safe, effective and caring and 'requires improvement' for responsive and well-led.

We visited all medical wards / areas and observed care being delivered. Before the inspection, we reviewed performance information from, and about the trust.

Medical care (including older people's care)

During the inspection we looked at 36 patient records, 21 prescription charts, spoke with 28 patients and relatives, and more than 70 staff including doctors, nurses, therapists, care support workers, ward managers, matrons, administrative assistants and student nurses. We also attended medical and nursing handovers, team meetings and operational site meetings.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We had concerns about the safety of medical care services with regard to; the number of serious incidents, some issues with medicines management, compliance with mandatory training among medical staff and the number of medical staffing vacancies which was impacting on cover arrangements and support and training of junior doctors.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England average and RTT performance had steadily deteriorated since 2015.
- Patients were not reviewed daily by a senior clinician and were not always reviewed by their specialty consultant/ team in a timely manner.
- There continued to be issues with delayed transfers of care, outlying patients, bed moves at night and mixed sex-accommodation breaches, although the trust was working on these and there had been some signs of improvement.
- There was no overarching, fully developed strategy or business plan for the medical service for 2018/2019. We were not assured that risks on the risk register were being actively managed or effectively overseen and there were still areas where junior nursing staff felt bullied and intimidated by middle managers.

However:

- Nurse staffing had improved since the last inspection and there were escalation processes in place to move staff to where they were needed most, based on ongoing risk assessments. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Levels of safeguarding training were around the trust target.
- The endoscopy unit had reapplied for JAG (Joint Advisory Group on Gastrointestinal endoscopy) accreditation in April 2018 and at the time of the inspection were waiting for final confirmation that this had been re-instated. There was a good system in place to ensure two week wait targets were met and urgent patients were seen quickly and there was now a 24-hour GI bleed rota in place.
- Staff cared for patients with compassion and involved them in decisions about their care. Feedback from patients confirmed that staff treated them well and with kindness.
- There had been changes to the senior management team and they had clear ideas and early plans for how the services needed to be developed. They were aware of the issues regarding pockets of bullying and had started to act to improve this situation. Staff spoke highly of the new Associate Chief Nurse and staff morale appeared to have improved since the last inspection and their appointments.

Is the service safe?

Requires improvement 

Medical care (including older people's care)

Our rating of safe went down. We rated it as requires improvement because:

- We were concerned about the number of serious incidents (SIs) within the medical service. Feedback to staff and shared learning from serious incidents was evident but ward managers did not receive collated information about other incidents, to learn from themes and trends. However, incidents were reported and staff were open and honest with patients when things went wrong.
- We had some concerns regarding medicines management which included; a lack of pharmacy support due to vacancies which meant there was little capacity to support or quality assure discharge medicines and undertake audits. Pharmacists felt that this carried a risk of unrecognised transcribing / labelling errors and a potential for under-reporting of this type of medicine related incidents. There were large numbers of expired drugs and patients discharge medicines in cupboards and fridges that had not been returned to pharmacy and some wards needed to rationalise the stock they held.
- Medical staff compliance with mandatory training was very poor with only one module around the trust target and only five modules having a compliance of over 50%. Compliance with mandatory training was below the trust target for nursing staff in four out of ten modules, but overall compliance was close to the trust target and an improvement on the previous year.
- This hospital had a medical vacancy rate of 24% at the time of inspection. There was still minimal medical cover at night, and capacity issues to manage outlying patients effectively. Patients did not always receive a daily senior review. The local deanery was not placing cardiology FY1 and FY2 doctors at the trust as there had been a lack of support and teaching available due to consultant pressures.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Nursing and medical staff compliance with safeguarding training was around the trust target.
- The nurse staff fill rate was around 97% for this hospital and although there were still registered nurse vacancies on the medical wards (7% vacancy rate), both the planned and actual numbers of registered staff had gone up. Escalation processes were in place to move staff to where they were needed most and staff felt the wards were better staffed than the previous year. Staff also reported that staff movement had reduced. However, there were wards that felt overstretched at times and shift coordinators and ward managers were often working in the numbers.
- Staff used appropriate tools for identifying deteriorating patients and patients with sepsis and audits showed good compliance with these tools and escalation processes. Nurses told us that medical response to escalated patients was prompt.

Is the service effective?

Good 

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The endoscopy unit had reapplied for JAG (Joint Advisory Group on Gastrointestinal endoscopy) accreditation in April 2018 and at the time of the inspection were waiting for final confirmation that this had been re-instated. There was a good system in place to ensure two week wait targets were met and urgent patients were seen quickly.

Medical care (including older people's care)

- The trust had introduced a seven-day, 24-hour, gastrointestinal bleed rota, which had now been embedded.
- Staff worked together as a team to benefit patients. 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. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- There were clinical skills educators employed by the trust to provide education and training to staff in the clinical / ward areas. Feedback from newly qualified nurses regarding training and support from the clinical skills team was excellent.
- Readmissions rates at Diana, Princess of Wales were lower than the England average in most elective and all non-elective admission categories.

However:

- There were mixed results in national audits. Whilst there was a lower risk of readmission and good performance in the Sentinel Stroke National Audit Programme, performance in the Heart Failure Audit and Lung Cancer Audit 2017 was mixed and the Myocardial Ischaemia National Audit Project and National Audit of Inpatient Falls 2017 were poor.
- From April 2017 to January 2018, 65% of staff within medical care services at this hospital had received an appraisal compared to a trust target of 95%. This was similar to the previous year.
- Not all medical patients received a senior medical review every day, particularly at weekends.
- Compliance with MCA and DoLS training was poor among medical staff.

Is the service caring?

Good

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. The response rate for the friends and family test was 51% which was better than the England average. From December 2016 to November 2017 most medical wards had consistently high recommendation rates between 90-100%.
- We saw staff treating patients with respect and preserving their dignity, sometimes in very difficult circumstances. Most patients described nursing staff as; caring, attentive, kind and explaining everything and updating patients regularly, despite being extremely busy. Some patients had used services over a number of years and spoke very highly of staff. Overall patients felt care from nurses and carers was very good.
- We saw and patients told us that staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment. We heard patients being given clear instructions in a way they could understand.

Medical care (including older people's care)

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The trust's referral to treatment time (RTT) for admitted pathways for medical services was consistently worse than the England average from January 2017 to December 2017. The position for December 2017 had deteriorated each year since 2015.
- Patient flow through the hospital remained an issue with a significant number of patients cared for on non-medical or non-speciality wards (outliers). Ward B4 (a surgical ward) was full of medical patients. A buddy ward system was in place however, there were still some issues with getting patients reviewed in a timely way.
- From February 2017 to January 2018 there were 841 reported delayed discharges, however, this was improving with the numbers falling from 89 in month one to around 65 in month 12, with one peak of 91 in month 10.
- Trust data showed that from January 2017 to December 2017 there were 308 patients moved at night at DPoW, usually ranging between 16 and 31 each month.
- There were 419 mixed sex accommodation breaches in the medical service at DPoW from February 2017 to January 2018, all in the cardiology area.

However:

- The endoscopy team had worked hard to reduce the number of two-week breaches and this had now been resolved and the unit had been re-accredited.
- The service took account of patients' individual needs and we saw some good examples of where staff had made special arrangements to meet an individual patient's needs.
- Staff on B4 had gone out of their way to meet the needs of patients with dementia.

Is the service well-led?

Requires improvement 

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

- The trust was in the middle of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the medical service for 2018/2019. However, services were developing plans which would feed into the new strategy.
- Two out of three of the senior leaders, of the medical service, the divisional clinical director (DCD) and the associate chief nurse (ACN) were relatively new in post and had not had time to fully develop the services and relationships with staff as they wished. However, they had clear ideas and early plans for how the services needed to be developed.
- Risks on the risk register were not being actively managed or effectively overseen as many risks had little information in the way of updates indicating that the reviewer was unaware of any progress.
- There were still areas where junior nursing staff felt bullied and intimidated by middle managers, and although the new senior leadership team were aware of this and had started to act to improve this situation, staff were unaware of what actions were being taken.

- Ward managers and shift coordinators had limited time for managerial functions as they were often needed to care for a cohort of patients instead of carrying out their planned duties for the day.

However:

- There was a clear leadership and governance structure and staff knew how to escalate issues and risks. All wards had a ward manager who were supported by operational and quality matrons and the ACN. Staff spoke highly of the ACN who was accessible, approachable and someone who listened to them. Staff morale appeared to have improved and staff reported feeling well-supported by their immediate line managers.
- The senior leaders promoted the idea of success and quality of care being dependant on engaging and caring for staff. The ACN and DCD had taken early steps to ensure staff were engaged in improving services. They were aware that there was a feeling among some staff that there were still pockets of bullying and intimidation and they were actively trying to identify specific areas of concern and act to improve this.
- The service engaged with patients and stakeholders to plan and there were plans to develop Cardiology services and an integrated Cardiology unit and to develop a Frail Elderly Care model based on the success of the Frail Elderly Assessment Team (FEAST) at SGH.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Requires improvement  

Key facts and figures

Surgical services at Northern Lincolnshire and Goole NHS Foundation Trust provides elective and emergency surgical care to patients.

The hospital has five surgical wards and eight operating theatres. The surgery directorate provides acute, elective and day case surgery covering 10 surgical specialities; including breast, colorectal, ear, nose and throat, general surgery, upper gastrointestinal, oral-maxillo facial, orthopaedics, trauma and urology.

The hospital has 137 inpatient surgical beds, including six high observation beds.

The trust had 43,026 surgical admissions from December 2016 to November 2017. Emergency admissions accounted for 9, 415 (21.9%), 3,685 (8.6%) were day cases and the remaining 29, 926 (69.6%) were elective admissions.

We inspected surgery on 8-11 May 2018 as part of an announced comprehensive inspection of the whole trust due to it being in special measures.

The trust was last inspected in October 2016, where all five domains in surgery were inspected and an overall rating of requires improvement was given. Well led was rated as inadequate, safe, effective, responsive were all rated as requires improvement and caring was rated as good.

The main areas of concern from the last inspection and the areas in surgery the trust was told to improve were:

- The trust must ensure that service risk registers are regularly reviewed, updated and include all relevant risks to the service.
- The trust must ensure that there are at all times sufficient number (including junior doctors) of suitably skilled, qualified and experience staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must monitor and address mixed sex accommodation breaches.
- The trust must ensure that, following serious incidents or never events, root cause and lessons learned are identified and shared with staff.
- The trust must ensure that effective processes are in place to enable access to theatres out of hours, and that all cases are clinically prioritised appropriately.
- The trust must ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently within surgical services.
- The trust must ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medicines are checked on a daily basis in line with the trust's policy.
- 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 (2015).

Surgery

- The trust must ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies.

We also said that the trust should:

- The trust should ensure that patients are assessed for delirium in line with national guidance.
- The trust should review the formal feedback process in place to collect patient or relative feedback.
- The trust should ensure that staff complete Mental Capacity Act training.
- 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 Patient Group Directives for nursing staff are completed and up to date.

During this inspection, we visited the surgical wards, operating theatres and recovery areas and day surgery unit. We spoke with 33 patients, two relatives and 71 members of staff. We observed staff delivering care and reviewed 21 sets of patient records and prescription charts. We reviewed trust policies and performance information from, and about the trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The directorate did not have a stable management structure in place. The divisional clinical director was new in post, the divisional general manager was in an interim role. The divisional head of nursing was the only member of the team that remained in post since the last inspection. This had an impact on the decision making, governance and oversight of the issues within surgery.
- We saw variable performance in national audits. Action plans we reviewed did not always address issues identified within the reports and actions had not had an impact on overall performance outcomes.
- The trust was not meeting the national performance standards for treatment or cancer standards. The trust referral to treatment time was consistently worse than the England average, fluctuating around 65%. Four out of six surgical specialities were worse than the England average performance.
- Overall mental capacity act training compliance for medical and dental staff was 55% and 77% for nursing staff which was worse than the trust target of 85%. We also saw one patient who lacked capacity was not supported to make decisions in line with relevant legislation and guidance. We also saw that DoLs applications were not available for all patients that required one.
- From prescription charts we reviewed on ward B6 we saw that medicines were not always prescribed or administered in line with national guidance.
- We had previously highlighted pre-assessment services required improvement in relation to clinical pathways, clinical cancellations of patients and competence of staff. At this inspection we did see some improvements in this service, however this needed more pace and a further period of embedding to provide assurance that the service was effective and responsive to clinical needs.

Surgery

- There were shortages of nursing and medical staff; these shortages were evidence in the majority of surgical areas. There was also high levels of bank and agency staff in use and some surgical areas had a low number of substantive permanent staff.
- The trust was in the process of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the surgical service for 2018/2019.
- Appraisal rates for staff were worse than the trust target. Seventy one percent of nursing staff had received an appraisal which was worse than the target of 95%.
- Policies, procedures and clinical decision making were not always based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE).

However:

- From our observations it was apparent that the five steps to safer surgery checklist, was embedded as a routine part of the surgical pathway.
- The majority of patients we spoke with were positive about the care and experience they had received.
- The service had systems in place for reporting, monitoring and learning from incidents. Staff we spoke with knew how to report incidents.
- We found wards and departments we visited clean and tidy, and we saw ward cleanliness scores displayed in public corridors.

Is the service safe?

Requires improvement 

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

- We had previously highlighted pre-assessment services required improvement in relation to clinical pathways, clinical cancellations of patients and competence of staff. At this inspection we did see some improvements, however we saw that some patients care and treatment was being delayed because of in-effective pre-assessment pathways. The changes needed more pace and a further period of embedding to provide assurance that the service was effective and responsive to clinical needs.
- There were shortages of nursing and medical staff; these shortages were evidence in the majority of surgical areas. There was also high levels of bank and agency staff in use and some surgical areas had a low number of substantive permanent staff.
- From prescription charts we reviewed we saw that medicines were not always prescribed or administered in line with national guidance.
- Overall mandatory training compliance for medical and dental staff was 57.6%, which was worse than the trust target off 85%. This figure had decreased significantly from the previous inspection.
- Of the safeguarding children's courses delivered by the trust twenty-four medical and dental staff and 25 nursing staff eligible for level two training had not completed it.

However:

Surgery

- At the previous inspection, we had highlighted that the five steps to safer surgery including the World Health Organisation (WHO) checklist, was not used effectively. During this inspection we saw improved practice and from our observations it was clear that the checklist was embedded as a routine part of the surgical pathway.
- We saw improvements in the process to identify patients who were deteriorating. We saw that staff had completed records correctly and saw evidence of appropriate escalation.
- We found wards and departments we visited clean and tidy, and we saw ward cleanliness scores displayed in public corridors.
- The service had systems in place for reporting, monitoring and learning from incidents. Staff we spoke with knew how to report incidents.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- We saw variable performance in national audits with some criterion performing worse than the national rate, some within the expected range and some performing better than expected. Action plans we reviewed addressed some of the issues identified within the reports but had not had an impact on overall performance outcomes.
- Food and fluid charts were not always completed accurately. Staff did not total the daily intake and output on all fluid balance charts we reviewed.
- Overall mental capacity act training compliance for medical and dental staff was 55% and 77% for nursing staff which was worse than the trust target of 85%. We saw one example where documentation for a patient who lacked capacity was not in line with relevant legislation and guidance. We also saw that DoLs applications were not available for all patients that required one.
- Records we reviewed, showed that on three out of four occasions patients had been fasted for too long pre-operatively, for example between 12-18 hours prior to surgery. The service did not complete audits on patient fasting times.
- Appraisal rates for staff were worse than the trust target. Sixty one percent of nursing staff had received an appraisal which was worse than the trust's target of 95%.
- Policies, procedures and clinical decision making were not always based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE).

However:

- At the previous inspection, we highlighted that there was not an effective process to enable access to theatres and ensure that all cases were clinically prioritised appropriately. From our observations at this inspection it was apparent that this had improved, for patients requiring surgery for a fractured neck of femur. We saw an improving position in relation to the proportion of patients having surgery on the day of or day after admission. This was 81.8% in 2017, which was worse than the national standard of 85% but better than the 2016 figure of 74.1%.
- Within surgery patients had lower than expected risk of readmission for both elective and non-elective admissions when compared to the England averages.

Surgery

- Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.
- Staff we spoke with said that they had good access to all information required to deliver services to patients.

Is the service caring?

Good  

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

- The majority of patients we spoke with described their care in positive terms. Patients we spoke with reported staff were caring and compassionate.
- We observed privacy and dignity being maintained for patients receiving care.
- We saw staff provide emotional support and reassurance to patients.
- The trust had multi-faith chaplaincy service and bereavement services, patients also had access to specialist nurses for further information and support when required.
- From speaking with patients and their relatives and reviewing care records, we found evidence of their involvement in care planning and delivery.

However:

- Friends and family response rates for the surgical directorate were worse at 23% than the England average of 29%.

Is the service responsive?

Requires improvement  

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Overall the percentage of cancelled operations at the trust was worse than the England average from January 2016 to December 2017.
- The trust was not meeting the national performance standards for treatment or cancer standards. The trust referral to treatment time was consistently worse than the England average, fluctuating around 65%. Four out of six surgical specialities were worse than the England average performance.
- The directorate did not respond to patient complaints within the trust timescale of 30 working days. The directorate currently took an average of 48 working days to close a complaint. Complex complaints had a target for closure of 60 working days and only 68% of all complaints were closed within this timescale.
- The number of medical outliers in surgical beds reduced the number available to deliver surgical services and led to increases in waiting times for surgical procedures.

However:

- The hospital performance for elective and non-elective length of stay for surgical patients was better than or similar to the England average.

Surgery

- From December 2016 to December 2017 the percentage of patients whose operation was cancelled and were not treated within 28 days had increased. However, in the most recent quarter (Q3 2017/18) 5% of patients whose operation was cancelled were not treated within 28 days this was better than the England average (8%).

Is the service well-led?

Inadequate 

Our rating of well-led stayed the same. We rated it as inadequate because:

- The directorate should have moved with more pace to address issues from the previous inspections, particularly pre-assessment of surgical patients.
- The directorate did not have a stable management structure in place. The divisional clinical director was new in post, the divisional general manager was in an interim role. The divisional head of nursing nurse was the only member of the team that remained in post since the last inspection. This had an impact on the decision making, pace of change, governance and oversight of the issues within surgery.
- The governance structure required strengthening to monitor performance and risks. This meant that the directorate did not have the recognition and oversight of all the risks to escalate issues to the board in a timely way.
- The trust was in the process of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the surgical service for 2018/2019.
- Directorate action plans did not always address all issues of poor performance highlighted within national audits, and in some cases performance was getting worse despite an action plan being in place. Action plans did not always reflect improvements seen at the Diana Princess of Wales hospital and ensure these were mirrored at SGH.
- The trust was not meeting the national performance standards for treatment or cancer standards, we had highlighted this at previous inspections, but performance continued to be worse than the England average performance.
- Policies, procedures and clinical decision making were not always based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE).

However:

- Staff morale was variable, it had improved slightly in some areas we visited. Staff we spoke with said that they felt supported.
- We were assured the trust had taken measures to address some of the issues raised at the last inspection but at the time of this inspection we were unable to see impact of the changes.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Critical care

Requires improvement 

Key facts and figures

Northern Lincolnshire and Goole NHS Foundation Trust has two critical care units. Diana, Princess of Wales Hospital has a six-bedded level two and three intensive care facility. This provides level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care. The unit has a bay containing four beds and two single rooms. The beds flexed between level two and level three as required. The unit could care for a maximum of six level three patients. This site also has a separate seven-bedded high dependency unit (HDU), which provides level two care.

Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2017 and 31 December 2017 on the intensive care unit at this site, there were 290 admissions with an average age of 61 years. Sixty six percent of admissions were non-surgical, 8% were planned surgical admissions and 26% were emergency surgical admissions. The average length of stay on the unit was two days.

A critical care outreach team provided a supportive role to the wards medical and nursing staff when caring for deteriorating patients and support to patients discharged from critical care. The team is available seven days a week. A recent change in their hours allows them to provide 12-hour cover during the day. Cover at night is provided by the hospital at night team.

The critical care service is part of the East Yorkshire and Humberside Critical Care Network.

The units did not accept paediatric admissions. The anaesthetist or consultants would attend in an emergency and stabilise the patient until a bed was available on the neonatal ICU or the dedicated intensive care transport service for children arrived. The unit had an inter hospital transfer policy which was in line with the critical care network and national guidelines.

Our inspection was announced as part of an announced comprehensive inspection of the whole trust due to it being in special measures. At the last inspection the responsive domain was rated requires improvement. The domains of safe, effective, caring and well led were rated good. We re-inspected all five key questions during this inspection.

During this inspection we visited the intensive care unit and the high dependency unit. We spoke with three patients and nine relatives and 31 members of staff. We observed staff delivering care, looked at 11 patient records and eight prescription 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.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The responsive domain improved and was rated as good. The caring domain remained good, however safe, effective and well led were rated as requires improvement.
- Medical staffing was not in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards and there were areas of training below the trust target.
- Some concerns were identified in relation to unit acquired infection rates and the management of clinical waste.

Critical care

- Appraisal rates and mandatory training figures were below the trust target and the number of staff with a post registration award in critical care nursing was less than the recommended 50%.
- Delirium screening was not taking place in HDU.
- We received mixed feedback from staff about leadership and culture within the units and few staff were aware of the vision and strategy for critical care.

However:

- The systems and processes in place for management of patient records and the assessment of patient risks were reliable and followed national guidance.
- Care was evidence based and feedback from patients and relatives was positive. The privacy and dignity of patients was maintained and care was compassionate.
- Access and flow through the units had improved and we found evidence of individualised patient care.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- We found the same situation with regards to medical staffing as at the previous inspection, in that it was not in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards as consultants had other areas of responsibility when on call and the rota did not provide continuity of care for patients.
- The number of unit acquired infections in blood was higher when compared to similar units, this was a deterioration from the previous inspection.
- Mandatory training compliance for medical staff was below the trust target. Mandatory training compliance for nursing staff on the high dependency unit was below the trust target. We were provided with conflicting figures with regards to mandatory training compliance for nursing staff on ICU.
- All areas of safeguarding training for nursing staff were below the trust target of 85%.
- We observed practice not in line with guidance for the management and storage of waste and used linen, and domestic input on HDU did not allow for daily cleaning of the floors.
- Incident data showed there had been occasions when pressure reliving mattresses were faulty or unavailable for patients on HDU.

However:

- Nurse staffing was in line with GPICS recommendations.
- Improvements had been made to the environment on ICU and facilities for respiratory isolation were available.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

Critical care

- Delirium screening was not being undertaken for patients in the HDU.
- Appraisal compliance rates for medical staff were 79%. For nursing staff in HDU they were 62% and 69% for ICU. These were all below the trust target of 95%.
- The number of staff with a post registration award in critical care nursing was 12% and had significantly reduced since the last inspection. This did not meet GPICS recommendations.
- Mental capacity act training compliance was below the trusts plan.

However:

- We found care was evidence based care and the process for sepsis and delirium screening was being done in the ICU. This was an improvement from the previous inspection.
- We found assessment and monitoring of pain and the nutritional and hydration status of patients was in place, and we observed care plans to support this.
- We observed and saw from reviewing records good examples of multidisciplinary team working.
- The appointment of a clinical educator meant there was a renewed focus on training and education for staff.

Is the service caring?

Good 

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

- Feedback from the patients and relatives we spoke with was positive. We observed care and interactions which were kind and compassionate and patient's privacy and dignity was maintained at all times.
- Staff recognised and responded to the emotional needs of their patients and relatives.
- The patient records we reviewed showed evidence of patient and carer involvement. This was supported by patients and the families we were able to speak with.

Is the service responsive?

Good 

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

- There had been improvement in the access and flow since the previous inspection. The number of bed days with a delay of more than eight hours was better than that of similar units.
- The percentage of non-clinical transfers was slightly higher than that of similar units; however, it was a significant reduction from the last inspection.
- Staff were able to identify and plan care to meet people's individual needs. They felt confident in providing care for patient who may require additional support, for example those with a learning difficulty or living with dementia.
- Follow up clinics were in place and appointments were offered to all levels three patients and those who had been on the unit for more than 72 hours.
- The unit received a low number of complaints.

However:

- There was no overnight accommodation for relatives.
- The service did not have a critical care patient and relative support group.
- At the time of the inspection the use of patient diaries was not embedded.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- We received mixed feedback with regards to the nursing leadership on the units and the visibility of senior nursing staff. Not all staff we spoke with felt supported.
- We identified that morale on the ICU was mixed. This was impacting the team and had also presented some challenges in terms of training and education for staff.
- Some concerns were identified in relation to staff being moved from critical care to other areas. We were assured managers were aware of this and were taking steps to resolve these issues.
- We found there was a lack of up to date patient safety and performance information displayed in the units.
- Very few staff were aware of the vision and strategy for the unit despite it being clearly outlined. The two units were functioning separately and there was limited inter-unit working.
- Work had been done to improve engagement with families and patients. However, the use of patient diaries was not embedded. The relaunch of patient diaries we saw at Scunthorpe had not been replicated at this site.
- We were provided with limited examples of innovative working. We were not aware of any involvement or participation in research.

However:

- Whilst still relatively new, governance processes had been strengthened with much more clinical oversight and ownership. The risk register was reflective of the risks to the service with evidence of recent review.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

The maternity service at Diana Princes of Wales Hospital (DPoW) has 37 beds. The service offers a labour, delivery, recovery and postnatal (LDRP) model of care. This means that women's care through labour, delivery, recovery and the postnatal period is delivered in the same room for their stay in hospital unless they need to go to the obstetric theatre. The community midwives care for women with low-risk pregnancies. There are three teams of community midwives who deliver antenatal and postnatal care in women's homes, clinics, GP practices and children's centres.

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

On the 15 June 2017, the Care Quality Commission (CQC) undertook an unannounced inspection. The purpose of this inspection was to follow up on the actions taken by the trust in relation to the Section 29A warning notice. The notice was issued in January 2017 following the previous inspection. (At that inspection we rated safe as inadequate, effective and well-led as requires improvement, caring and responsive as good. The overall rating was, requires improvement).

At the follow up inspection in June 2017, which was inspected but not rated, we found:

- Actual midwifery staffing levels did not always match the planned midwifery staffing levels.
- Whilst staff told us that sharing information and learning from incidents had improved on the unit, we were not assured that changes in practice had been fully embedded following a further never event relating to a retained swab.

During this inspection, we visited the maternity unit and spoke with three patients and 24 members of staff. These included matrons, ward managers and midwives. We observed care and treatment, looked at 14 patient records and medicines charts. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of the service at DPoW, Scunthorpe General Hospital and Goole District Hospital.

Summary of this service

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated it as good because:

- Good governance processes were in place and good systems for risk management. A risk management and patient safety strategy were in place, and the maternity services risk register was monitored and updated.
- The management structure had clear lines of responsibility and accountability and there was a strategic vision for maternity services.
- The group clinical director had recently come into post prior to our inspection. Staff reported they were confident in this person to lead the clinical team.
- The interim head of midwifery had a positive impact on the culture within maternity services.
- The service had established an 'NLaG Outstanding Midwife' award and had developed local events to celebrate midwifery staff.

Maternity

- We observed good team working, with midwives working collaboratively and with respect for each other's roles. All staff spoke positively and were proud of the progress the service had made since our inspection in 2016.
- There was a Maternity Voices Partnership in place at the trust. Parents who had a child at the trust in the last three years were invited to join and share their experiences of care.
- Procedures were in place to refer and safeguard adults and children from abuse. Staff felt confident making referrals and received safeguarding supervision.
- Record keeping was of a good standard. Staff used 'fresh eyes' reviews of cardiotocography (CTG) for all women during labour, risk assessments were taking place and escalated appropriately.
- Staff were encouraged to report incidents and systems were in place following investigation for monitoring and sharing lessons learned with staff.

However:

- Not all medical and nursing/midwifery staff were up to date with mandatory training. This included Mental Capacity Act and Deprivation of Liberty Safeguarding training. They were not meeting the 85% training compliance target set by the trust.
- The consultant medical staffing hours on labour ward were not in line with the Royal College of Gynaecologist (RCOG) guidelines, and the trust's Policy for safe Staffing Levels for Obstetricians, Midwifery and Support Staff.
- Women told us they all received 1:1 care during established labour. However, from March 2017 to February 2018, data provided by the trust showed that 84.8% of women received 1:1 care in labour cross the trust. Following the inspection the trust told us that the figures provided for 1:1 care, did not include women whose babies were delivered by caesarean section. However, the trust did not provide updated figures which included these births.
- From April 2017 to March 2018, the community caseload staffing levels was 135 women per midwife. The current recommended Birth-rate plus ratio, allowing for some changes in the NICE Guidance since 2009, is 96 cases per WTE midwife.
- Medical and nursing/midwifery staff were not up to date with their appraisals. They were not meeting the trust compliance target of 95%.
- Several policies were past their date of review and the trust was aware of this. However, each out of date policy was allocated to a member of staff to review and update; within a specific timeframe. A policy review group was also in place. We were assured by the management team that the out of date policies would be updated quickly.

Is the service safe?

Requires improvement 

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated safe as requires improvement because:

- At our inspection in November/December 2016 the service was inadequate for safe, and in June 2017, when the service was inspected and not rated, we found improvements were made. At this inspection, the trust had followed their action plan to address their shortfalls and we found progress and further positive improvements made. Several serious incidents were reported and the main theme identified was bladder care. Staff were aware of this and the action taken to help prevent further concerns.

Maternity

- Medical, nursing and midwifery staff were not meeting trust targets for mandatory training. This included the Mental Capacity Act and Deprivation of Liberty Safeguarding training.
- Medical and nursing staff were not meeting the trust target of 85% for safeguarding training. For example, 68% of medical staff had completed the training and 71% of nursing and midwifery staff had completed safeguarding level one training.
- The consultant medical staffing hours on labour ward was not in line with the RCOG guidance. This was because consultant obstetricians worked in antenatal clinic when covering labour ward. Therefore, not providing 60 hours labour ward cover.
- The birth to midwife ratio did not meet the national minimum recommendation of 1:28. Women told us they received 1:1 care during in established labour. However, from March 2017 to February 2018, data showed 84.5% of women received 1:1 care in labour across the trust.
- The community midwife caseloads were 1:136 against the national guidance of 96 cases per WTE midwife.

However:

- Records relating to women's care were of a good standard. Records were kept secure in line with the data protection procedures.
- Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in obstetric theatres an adaptation of the World Health Organisation (WHO) surgical safety checklist.
- Procedures were in place to refer and safeguard adults and children from abuse. Staff felt confident making a safeguarding referral and received safeguarding supervision.
- Staff were encouraged to report incidents, received feedback and there was evidence of learning from incidents taking place.

Is the service effective?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated effective as good because:

- Following our inspection in June 2017, a clinical skills and patient safety midwife has been recruited. The purpose of this role was to be clinically based, highly visible, coordinate the delivery of training and ensure development of the maternity workforce.
- Community midwives were trained in postnatal check up's and new-born and infant physical examination (NIPE). This would allow women to be discharged from hospital earlier, with the proviso that new-born babies would receive a NIPE check in the community within 72 hours.
- All women said they could access pain relief in a timely way, analgesia was offered regularly and their pain was well managed.
- Midwifery staff both in the hospital and community reported good communication. This included information sharing between departments and cross-site working within teams.

Maternity

- There was a dedicated infant feeding team with a remit to provide support services across the trust and including the community. The service was open to referrals from any health and social care professional, and women could self-refer.
- Midwives and nursing staff could articulate how they would ensure consent was obtained either verbally or written prior to a procedure.
- Outcomes for women were largely positive. The stillbirth rate total was better than the trust target threshold, the proportion of women who had a non-interventional delivery had decreased and women who experienced a post-partum haemorrhage were lower than the Yorkshire and Humber average.

However:

- The proportion of women who experienced a third or fourth degree tear following an assisted delivery was above the Yorkshire and Humber average in quarter three of 2017 to 2018. The trust had processes in place to help reduce the incidence of tears.
- The service did not meet their appraisal rate of 95% for medical staff, nurses and midwives.
- The service provided care and treatment based on national guidance. However, several policies were past their date of review. The trust was aware of this and allocated members of staff to review and update the policies within a specific timeframe.

Is the service caring?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated caring as good because:

- Staff involved women in their care and treated them with compassion, kindness, dignity and respect. When in labour, women were encouraged to bring their birthing partners with them, and they were made to feel welcome.
- A review of maternity services at the site was undertaken by representatives from the trust, local Clinical Care Commissioning groups (CCG), and Healthwatch was carried out 28 September 2017. Findings stated all women spoken with had a lot of praise for the caring nature of staff in the wards, delivery suite and theatres. Staff were said to go “above and beyond” and their approach was consistently caring.
- There were guidelines and care pathways to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death.
- There was a specialist bereavement midwife-led ‘rainbow clinic’. The ‘rainbow clinic’ was a specialist service for women and their families in a subsequent pregnancy following loss; and women could self-refer. A specialist bereavement midwife was in post, who worked across sites.

Is the service responsive?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated responsive as good because:

- Women could book their initial antenatal appointment directly, by telephone or online and did not require referral.
- The service met the trust target for undertaking antenatal bookings before 13 weeks gestation (minus the agreed exclusion targets such as mothers presenting later in pregnancy). Procedures were in place to follow up women who did not attend.
- There were no maternity unit closures for the 12 months prior to inspection.
- Women were offered the choice to deliver at home, in a midwifery-led birthing suite, or in hospital.
- A face-to-face and telephone translation service was available, provided by 'Big Word Translation' services and British Sign Language signers.
- The trust had also applied assistive technology to their external web pages, to enable audio capabilities for those with visual impairments. The assistive technology allowed users to listen to an audio reading of web content in different languages.
- Staff were clear about the complaints process and action they should take if someone wished to complain.

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings. We rated well-led as good because:

- The group clinical director had recently come into post prior to our inspection. Staff reported they were confident in this person to lead the clinical team.
- The service had a three to five-year strategy which reviewed clinical and financial pressures.
- They also told us that the interim head of midwifery had a positive impact on the culture within maternity services.
- The service had established an 'NLaG Outstanding Midwife' award and had developed local events to celebrate midwifery staff.
- The management structure had clear lines of responsibility and accountability, and we saw evidence of frequent maternity services meetings and panels, which were appropriately attended.
- Good governance processes were in place and good systems for risk management. A risk management and patient safety strategy were in place, and the maternity services risk register was monitored and updated.
- The service used internal, cross site communication methods to inform staff of learning and changes to practice (for example, the weekly learning memorandum from the interim head of midwifery). We found highlights posted on staff notice boards and minutes of meetings where staff signed to show they were aware of the information.

However:

- The service was receiving support from NHSI in the form of an external partnership with a consultant. The aim was to support the leadership team to drive improvement. At the time of inspection support had been provided of six days and was in the early stages.
- Staff across the Women and Children's Group completed a survey in 2017, facilitated by an independent provider. Poor scores for organisational culture were noted and staff felt this was a critical situation requiring leadership changes to avoid organisational failure.

Maternity

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Good ↑

Key facts and figures

Children's services at Diana, Princess of Wales Hospital include an 18-bed inpatient ward, with two high dependency beds; a paediatric assessment unit, open from 10am until 9/9.30pm every day; a 12-cot neonatal unit and six-cot transitional care ward; a children's outpatient department, a child development centre and a children's community nursing team.

The children's ward admitted children up to the age of 16 years or 18 years for those young people with chronic or complex conditions.

At our last inspection, we rated safe, effective, responsive and well led as requires improvement. Caring was rated as good.

We inspected services for children and young people on 8-11 May 2018 as part of an announced comprehensive inspection of the whole trust due to it being in special measures.

During the inspection visit, the inspection team visited the inpatient ward, the paediatric assessment unit, the neonatal unit, children's outpatients and the child development centre. We also visited adult outpatient areas that saw children and young people. We spoke with ten parents and their children, the service leads, 37 other staff members including nursing staff, medical staff, play staff and administration staff, observed a medical handover and reviewed 17 sets of records.

Summary of this service

Our rating of this service improved. We rated it as good because:

- We rated effective, caring, responsive and well led as good. Safe was rated as requires improvement.
- Staff had a good understanding of safeguarding and were aware of their responsibilities in relation to this.
- Patient records were completed to a good standard.
- The paediatric early warning score (PEWS) tool had been improved since our last inspection and we saw appropriate assessment and escalation of children and young people.
- Staff understood their responsibility to report incidents and feedback from incidents was shared in a number of ways.
- Staff provided care and treatment in line with national guidance. The service monitored the effectiveness of care and treatment through local and national audits.
- Patient outcomes were in line with or better than the national average.
- There was effective multidisciplinary team working, both internally and externally.
- Staff understood their responsibilities when obtaining consent from young people and their parents/carers.
- Staff treated patients and their families with kindness and compassion, encouraging family members to be involved in their child's care.

Services for children and young people

- The children's services met the individual needs of children and provided a range of therapeutic interventions and specialist nurses.
- Staff we spoke with told us leaders were visible, approachable and supportive. Leaders were aware of the risks to the service and had plans in place for the management of risks.
- Effective governance processes were in place to manage risk and quality.

However:

- Medical staff were still not meeting trust targets for mandatory training and safeguarding training.
- There was no formal risk assessment tool for those patients with mental health concerns and staff had no specific training to deal with patients with mental health needs.
- Medical staffing was not compliant with national guidance.
- Children's services were not meeting the Accessible Communication Standards (2017) concerning the communication needs of parents/carers.

Is the service safe?

Requires improvement 

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

- Medical staff were not meeting the trust target for compliance with mandatory training and level three safeguarding training. This had been identified as a concern at our last inspection.
- Nurse staffing on the paediatric assessment unit was not compliant with national guidance.
- The paediatric assessment unit did not have its own resuscitation trolley and had to use the paediatric trolley in the accident and emergency department.
- Access to the paediatric assessment unit was not secure.
- There was no formal risk assessment tools used for those patients with mental health concerns.
- Medical staffing was not compliant with national guidance. This had been identified at our last inspection and some improvements had been made. A business case had been put forward for increased staffing.

However:

- We saw that appropriate safeguarding referrals were made and staff accessed safeguarding supervision.
- A new paediatric early warning score (PEWS) tool had been introduced since our last inspection and we saw appropriate recording and escalation of PEWS scores.
- Nurse staffing on the ward had improved since our last inspection, with a band six nurse available on most shifts.
- Records were appropriately completed and stored securely.
- Incidents were reported and staff received feedback.

Services for children and young people

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance. All polices and guidance we reviewed was up to date.
- Patient outcomes were in line with or better than the national average.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. We saw evidence of good communication between ward staff and the child and adolescent mental health service (CAMHS).
- Staff understood their responsibilities when obtaining consent and were aware of Gillick competency.
- Transition services had improved since our last inspection and the service was in the process of developing a clinical nurse coordinator for complex care role, whose role would include overseeing the transition process.

However:

- Staff had not received any training to help them support children and young people with a mental health condition.
- Appraisal rates were worse than the trust's own target levels, despite staff telling us they had completed their appraisals. Information provided by the trust showed appraisal rates varied from 0% to 84%.

Is the service caring?

Good → ←

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

- Staff cared for patients with compassion and respect. Feedback from patients confirmed that staff treated them with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment. There was engagement through the friends and family test (FFT) which showed consistently positive results.
- Staff provided emotional support to patients to minimise their distress. Play specialists were available to alleviate anxieties.
- The children's ward had a link nurse for bereavement and end of life care.
- Information was provided to parents in a way they could understand.

Is the service responsive?

Good ↑

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

- The children's community nursing team and the specialist nurses promoted early discharge.

- People could access the service when they needed it. Waiting times for treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Facilities and premises were appropriate and child friendly with a play area and an adolescent room available.
- The child development centre provided a range of services and therapeutic interventions for children with complex needs.
- There was ongoing work with the commissioners to provide a service that met The National Institute for Health and Care Excellence (NICE) guidance for those children requiring an assessment for a diagnosis of autism.

However:

- Children's services were not meeting the Accessible Information Standards (2017), as parents and carers communication support needs were not routinely identified.

Is the service well-led?

Good  

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

- There was good and effective local management, who were visible. Staff we spoke with talked positively about their leaders and the executive team.
- Service leads understood their local challenges. Improvements had been made since our last inspection and the service leads recognised and identified their areas for further improvement.
- There was a clear and effective governance structure in place, which ensured information was fed from ward to board, and from board to ward.
- Morale had improved since our last inspection and staff we spoke with talked positively about the service.
- There was a strategy in place for the children's services. However, staff we spoke with told us they had only seen the strategy in the week prior to our inspection.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

End of life care

Requires improvement 

Key facts and figures

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

The End of Life (EOL) Team consists of an EOL clinical coordinator for the acute trust, an EOL lead nurse in the community and an EOL Clinical Practice Educator. They work closely with clinical staff caring for patients with non-complex palliative needs and provide education.

In North Lincolnshire there are also Specialist Palliative Care teams in both Scunthorpe General Hospital and community lead by a consultant in palliative medicine. In North East Lincolnshire Care Plus Group provide specialist palliative care teams at Diana Princess of Wales Hospital and North East Lincolnshire community.

There is a discharge liaison team at Scunthorpe General Hospital dedicated to co-ordinating fast track discharges in a timely manner and this is mirrored by the Haven Team at Diana Princess of Wales Hospital.

The trust had 1,669 deaths from December 2016 to November 2017.

We inspected the hospital as part of an announced inspection between 8 and 11 May 2018. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring performance.

We reviewed four records for patients at end of life and a further two adult admission records. We reviewed eight records of do not attempt cardio pulmonary resuscitation (DNACPR). We spoke with one patient and those close to them as well as observing care of one patient on the wards.

We spoke with 26 members of staff including the end of life co-ordinator, the palliative care consultant, Care Plus Macmillan nurses and the Haven team, bereavement officer, nurses of all grades, doctors, the chaplain, mortuary staff and porters.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Compliance with end of life mandatory training was below the trust target for nurses.
- There was only one palliative care consultant with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service did not manage patient safety incidents. Staff did not recognise incidents as end of life and report them appropriately.
- The service did not always monitor the effectiveness of care and treatment and used the findings to improve them.
- The service was not available over seven days: it was Monday to Friday only, with out of hours telephone advice and discharge support outside of this

End of life care

- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. We saw do not attempt cardio pulmonary resuscitation (DNACPR) documentation was not consistently or appropriately completed.
- Patients, together with their families and carers, were not always included in discussions regarding capacity assessment or DNACPR decisions.
- There was one complaint identified as end of life and this had not been managed in a timely manner.
- The service did not have sufficient numbers of senior managers with the right skills and abilities to run a service providing high-quality sustainable care. There was one consultant to provide cover for both hospitals and the community palliative care services.
- The service did not have a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Whilst the end of life strategy group had identified areas for improvement, overall progress towards these was slow.
- The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risk assessments for patients with mental health needs were not always identified.

However:

- The service prescribed, gave, recorded and stored anticipatory medicines well. Patients received the right medication at the right dose at the right time.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff worked together as a team to benefit patients. Specialist palliative care staff and ward staff supported each other to provide good care.
- Staff cared for patients and those close to them with compassion. Feedback from patients confirmed that staff treated them well and with kindness and provided emotional support.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- The service provided mandatory training in end of life skills to staff in the trust, compliance was below the trust target of 85% for nurses. This training was not mandatory for medical staff.

End of life care

- The service had only one palliative care consultant with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. This was not in line with national guidance.
- The service did not manage patient safety incidents. Staff did not recognise incidents as end of life and report them appropriately. There was no shared learning or feedback for incidents that may have been in relation to end of life care.

However:

- The service prescribed, gave, recorded and stored anticipatory medicines well. Patients received the right medication at the right dose at the right time.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The trust performed worse than the England average for three of the six clinical indicators in the End of Life Care audit: Dying in Hospital 2016. At the time of the inspection not all actions on the trusts action plan were complete.
- The service was not always following best practice, for example, there was currently no recommended summary plan for emergency care and treatment for patients (ReSPECT) in place. ReSPECT includes a plan for future care to guide health professionals to providing the appropriate care and treatment. There was currently no electronic palliative care co-ordination system (EPaCCS) in place.
- The service was not available over seven days: it was Monday to Friday only, with support for patient discharge on Saturdays. Out of hours telephone support was available at weekends and evenings, provided by the local hospice
- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. We saw doctors did not complete do not attempt cardio pulmonary resuscitation (DNACPR) documentation in line with trust policy or legislation.
- The end of life clinical practice educator had left their post in the week prior to inspection. Temporary cover for this role was being provided by the End of Life clinical co-ordinator based at Scunthorpe hospital.

However:

- The appraisal rate for the specialist palliative care team and for the end of life clinical co-ordinator was 100%.
- Following the inspection, the trust provided an updated action plan which identified that all recommendations had been implemented following the End of Life Care audit: Dying in Hospital 2016.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. A wide range of different professionals were involved in providing care for patients at end of life.

End of life care

Is the service caring?

Good  

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients' relatives spoke appreciatively about the care their relative had received.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress. We observed staff treating patients sensitively and respectfully.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- Between April 2017 and March 2018 719 patients died at the hospital. Of this number 25% of patients had a care in the last days of care document in place and 48% of these patients had discussed their preferred place of death. Information provided by the trust in the showed that 43% of patients whose preferred place of death was hospital achieved this at DPoW.
- The end of life facilitator post at DPoW was currently vacant and the impact of this for timely referral of end of life patients was not known.
- Staff informed us that lack of available side rooms for patients receiving care in last days of life could have impact on the privacy and dignity of patients.
- Documentation for advanced care planning had been introduced during the last 12 months, however we saw limited used of this document in practice and staff told us this was still in development.
- Complaints were not always managed in a timely manner.

However:

- The service took account of patients' individual needs. Care plans identified patients' individual preferences and these were reviewed frequently. Patients with an additional need, such as dementia, were provided with appropriate support.
- People could access the service when they needed it during weekdays. Arrangements were in place to support rapid discharge for end of life patients where this was requested.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

End of life care

- The service did not have sufficient numbers of senior managers with the right skills and abilities to run a service providing high-quality sustainable care. There was only one palliative care consultant, providing care for both hospitals and the community palliative care services.
- Leadership arrangements for end of life care at trust board level were unclear during our inspection however, following the inspection the trust told us that the chief nurse was the executive lead as well as the interim medical director being executive lead for mortality.
- Whilst a service level agreement was in place for palliative care services, the arrangements for out of hours cover were insufficient. There was an over-reliance on the palliative care consultant for all leadership.
- The service did not have a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Whilst the end of life strategy group had identified areas for improvement, overall progress towards achieving these was slow.
- The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risk assessments for patients with mental health needs were not always identified.
- The trusts own audit results did not always reflect what we found in patients records on inspection.

However:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service, were passionate about providing good end of life care, they promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff felt supported and were proud of the services they provided.
- The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Inadequate

Key facts and figures

Outpatients was part of the clinical support services directorate. Pathology was provided by a service managed by the trust and provided services to other trusts. There were four zones at outpatients at Diana Princess of Wales Hospital (DPoW), zone one was ophthalmology, zone two, zone three and four were general outpatients. A range of clinics were provided by outpatients such as surgery outpatients, medicine outpatients, ophthalmology, respiratory, diabetes, urology, neurology and ear, nose and throat.

Outpatient services were provided on all three hospital sites in dedicated outpatient areas. The majority of clinics were provided during core hours; however, a small number of evening and weekend clinics took place. Waiting lists for each speciality were held and managed by that speciality.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. The inspection was part of a comprehensive inspection. We visited Goole and District Hospital outpatients, Scunthorpe Hospital outpatients and Diana, Princess of Wales Hospital outpatients at the trust during the inspection. We inspected outpatients as part of this inspection as at the previous inspection outpatients was rated as inadequate and we found a number of concerns within the core service.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

During the inspection we visited general outpatients, cardiology outpatients, ophthalmology outpatients, phlebotomy, diabetes centre and podiatry outpatients.

Between November 2016 and October 2017 there were 216,993 outpatient appointments at DPoW hospital.

We spoke with 23 patients, 47 staff and reviewed eight patient records during our inspection.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our

new ratings directly with previous ratings. We rated the service as inadequate because:

- There were 31,295 patients overdue their follow up appointment as at March 2018. This was worse than the previous inspection.
- The trust had started to clinically validate and administratively validate some waiting lists; however, this was not complete across all waiting lists.
- Referral to treatment indicators were not met across all specialities. This had not improved since the previous inspection.
- There were 320 patients waiting over 52 weeks at the trust as at March 2018. This was worse than the previous inspection.
- The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral.

Outpatients

- At our last inspection we reported medical records were not stored securely. At this inspection we found three separate areas in outpatient clinics where medical records were left uncovered, unsupervised and in open areas.
- From November 2016 to October 2017; the 'did not attend' rate for Diana, Princess of Wales Hospital was higher than the England average.
- The trust did not investigate and close complaints in line with its own target.
- There was no formal strategy for outpatients at the trust and staff were not always aware of the trust vision and values.

However:

- We found nursing staff had exceeded the mandatory training completion.
- Nursing staffing levels were generally as planned in outpatients.
- Staff had access to trust policies. Audits were completed within specialities.
- Staff we spoke with were friendly and provided compassionate care to patients and ensured privacy and dignity was maintained. Patient feedback regarding services was generally positive.
- Staff told us morale was generally good across the services.

Is the service safe?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated safe as requires improvement because:

- The previous inspection found that clinical validation and assessment of risk within waiting lists had been slow to be implemented across all specialities. The trust had started to clinically validate some waiting lists; however, this was inconsistent and not complete across waiting lists in all specialities.
- At this inspection clinical validation in terms of clinical harm reviews had been commenced, but not been completed, across all specialities. Clinical validation was only being completed on patients on waiting lists where they were six months overdue their appointment date, waiting in excess of 40 weeks for treatment and confirmed cancer patients waiting over 104 days for treatment This did not provide assurance that there was clear oversight of the risk posed to patients on waiting lists. This did not provide assurance that there was clear oversight of the risk posed to patients on waiting lists.
- The trust declared a serious incident in May 2018 that related to a delay in a patient receiving treatment. This was found during a validation exercise.
- The clinical harm review of the patients overdue six months or more for their appointment was ongoing; however, was not yet complete at the time of our inspection. The clinical harm group had identified patients who had died whilst waiting for a follow up appointment; however there had been no formal reviews of these deaths to see whether the delay in appointments or treatment may have contributed to the patient deaths.
- The total number of patients on waiting lists had increased since the previous inspection.
- At our last inspection we reported medical records were not stored securely. At this inspection we found three separate areas in outpatient clinics where medical records were left uncovered, unsupervised and in open areas and not always completed in line with professional standards.

Outpatients

However:

- Nursing staff met or exceeded the trusts completion target for all mandatory and safeguarding training modules.
- All areas we visited were visibly clean and tidy. Medicines were stored securely in all but one area visited.
- Nursing staffing levels were as planned in outpatients.
- Staff we spoke with were aware of reporting incidents and using the incident reporting system and were aware of the duty of candour.

Is the service effective?

Not sufficient evidence to rate

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We did not rate effective.

- Staff had access to a trust intranet which contained the trust policies and procedures available to staff.
- Audit was generally carried out within the specialities that provided outpatients. A number of clinics we visited told us they completed annual audits.
- Staff we spoke with in outpatients told us they were able to provide drinks to patients who had waited a long time or who required a drink.
- From November 2016 to October 2017; the follow-up to new rate for Diana, Princess of Wales Hospital was similar to the England average.
- Staff had received annual appraisals and staff we spoke with had generally had opportunity to develop and complete further training.

Is the service caring?

Good

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated caring as good because:

- We observed staff of all grades interacting with patients. Staff introduced themselves, were friendly and welcoming and were quick to offer help when required.
- Overall, patient feedback was positive and staff were described as being caring and considerate.
- Patients we spoke with told us they felt supported and treated with dignity, respect and felt involved in the planning of their care.
- Clinical nurse specialists were available in a number of clinics to provide further support to patients.
- Chaperones were available where required in clinics and there was information available regarding chaperones in outpatients.

Outpatients

Is the service responsive?

Inadequate

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated responsive as inadequate because:

- The previous inspection found issues with referral to treatment indicators. During this inspection we found that referral to treatment indicators were not met across all specialities. There was no clear plan for recovery or a trajectory to improve referral to treatment performance.
- The previous inspection found concerns with the number of patients overdue their appointment. During this inspection we found there were 31,295 patients overdue their follow up appointment as at March 2018. This was worse than the previous inspection. During this inspection we found there were still patients without an appointment due date.
- From November 2016 to October 2017; the 'did not attend' rate for Diana, Princess of Wales Hospital was higher than the England average.
- There were 320 patients waiting over 52 weeks for an outpatient appointment at the trust as at March 2018. There was no clear plan for recovery or a trajectory to improve the 52 week wait performance.
- The trust was performing worse than the 85% operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral. There was no clear plan for recovery or a trajectory to improve the 62 day cancer pathway performance.
- The outpatients booked slot utilisation rate was below the trust target of 95%. In April 2018 at DPoW it was 87%.
- The service did not investigate and close complaints in line with the trust's target.

However:

- The trust was performing 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).
- Senior managers we spoke with told us they met regularly with the clinical commissioning groups regarding service delivery and attended regular business meetings for outpatients.
- Outpatient clinics had various patient information leaflets they could provide to patients and. translation services were available in outpatients.
- The trust had introduced a lead for patient administration and access to address the concerns raised at the previous inspection.

Is the service well-led?

Inadequate

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated well led as inadequate because:

Outpatients

- Since the introduction of a patient administration and access lead for outpatients, areas such as booking appointments and staff training on referral to treatment standards had improved; however, the pace of work and increasing waiting lists remained a significant concern.
- Staff we spoke with at all levels in the trust were not always clear on the actual number of patients on waiting lists.
- Concerns and challenges around referral to treatment indicators and the number of patients overdue their follow up appointments had not been fully addressed at this inspection. The trust was working on addressing the issues; however, the overdue follow up patient backlog had increased since our last inspection. There was no clear improvement trajectory for the 31,295 patients follow up backlog.
- There had been an increase in patients waiting over 52 weeks for an appointment and no clear plan to address concerns regarding this or the 62 day operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral.
- At the time of the inspection the trust did not have an effective performance management framework in place. Work had begun to encourage ownership of performance in the divisions.
- There was no formal strategy for outpatients at the trust.

However:

- There was a management structure for outpatients and governance systems in place. Risks were documented on risk registers which were reviewed monthly.
- Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available for support when required. Morale was generally good in outpatients and staff felt supported.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diagnostic imaging

Requires improvement

Key facts and figures

Diagnostics and radiology were part of the clinical support services directorate. There were three diagnostic imaging departments plus a medical physics department at Diana Princess of Wales Hospital (DPoW), Grimsby. The diagnostic and radiology department at DPoW carried out CT, MRI, PET, ultrasound, fluoroscopy and a range of invasive procedures such as biopsies and injections using scans as a guide.

The department supported an external provider who carried out MRI and CT scans by providing consumables and an emergency box. The patients were all trust patients however staff and equipment were supplied by the external provider.

Radiology services were provided on all three hospital sites in dedicated diagnostic imaging suites. The departments at DPoW were open seven days a week with on call services available overnight to support emergency and urgent patients.

Clinical Support Services role was to provide radiography and nursing staff, administration support for receptions and all of the health records functionality. Waiting lists for each modality were managed by that modality.

During the inspection we visited the diagnostic and radiology departments, medical physics department and Pink Rose Suite.

We spoke with 25 staff across all modalities and from different disciplines and nine patients and carers on this inspection.

Summary of this service

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Medical staffing was low across the trust with significant vacancies and those medical staff in place were not up to date with mandatory training.
- The department did not have sufficient MRI and CT scanning equipment to meet increasing demand.
- MRI and CT scanning equipment and other radiological equipment was not reliable and had suffered multiple break downs. Some equipment was classed as end of life and when it broke down, new parts were not always available meaning reconditioned parts had to be used. There were a number of equipment risks recorded on the risk register.
- Patients had long waits to undergo scans, waiting lists were increasing and there was a risk of patient harm because of these long waits.
- Once treated, patients had long waits to receive the results of their tests. This was a trust wide problem compounded by low medical staffing numbers.
- Waiting times for patients on urgent treatment pathways were difficult to meet at DPoW.

Diagnostic imaging

- At the time of the inspection we did not see evidence that the department was participating in local clinical audit and was therefore unable to provide evidence that policies and procedures were being adhered to. However, after the initial report was written, the trust sent us evidence to show some clinical audit was being carried out by radiologists.
- There was no evidence of patient engagement in the department.
- Staff did not always feel valued or have their contributions recognised by the senior management team.
- Implementation of the trust wide five year strategy for diagnostics and radiology was behind schedule and this was having an impact on the trust's ability to meet demand across all sites.

However:

- There were processes in place to ensure patients and staff were not over exposed to radiation and sufficient staff had completed mandatory training to support patient needs.
- The department was clean and tidy.
- Patients were seen quickly on arrival and there were facilities to meet their individual needs.
- Staff had access to policies and procedures based on best practice.
- Staff were aware of their responsibilities relating to consent, mental capacity and safeguarding of vulnerable people.
- Performance against national and local standards, targets and performance indicators was closely monitored and there was a governance process.
- Staff felt well supported locally by their manager and colleagues and the culture of the department was patient centred. The wider trust had started to engage with staff although this was a work in progress.

Is the service safe?

Requires improvement

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated safe as requires improvement because:

- There was insufficient scanning equipment in the department to meet patient demand.
- Some equipment was classed as end of life, broke down frequently and was not able to be fixed with new parts. Second hand and reconditioned parts were unreliable and did not always last very long. This had an impact on patient waiting times and meant appointments had to be rearranged.
- There were trust wide shortages of radiologists. This impacted on reporting rates across the trust, including DPoW.
- The department had not carried out any reviews of patients who had experienced delays to check whether the delay had impacted on their diagnosis, treatment or prognosis.
- Medical and radiography staff who worked across the trust did not meet the target for adult safeguarding training, prevent training and resuscitation training.
- There had been three incidents when patients had come to possible harm because of missed opportunities to diagnose potential serious health conditions either due to delayed reporting, delayed notification of results or failure to notice changes on subsequent scans.

However:

Diagnostic imaging

- All areas we visited were visibly clean and tidy. We saw department staff participate in hand hygiene activities and we observed equipment being cleaned.
- Staff were aware of the risks associated with working with ionising radiation and followed safety guidance to protect themselves and their patients
- Managers told us there were no current concerns with radiographer staffing numbers at DPoW and additional locum staff were accessible.
- There were limited supplies of medicines used in the department however these were stored appropriately and securely.
- Equipment was maintained in line with manufacturer requirements.
- From January 2017 to December 2017, the trust reported no incidents classified as never events and no serious incidents for diagnostics and radiology.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.

Is the service effective?

Not sufficient evidence to rate

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We did not rate effective.

However:

- Staff in radiology told us they could provide drinks to patients who had waited a long time or who required a drink. Light snacks were also available for patients who had medical conditions.
- Patients who required pain relief as part of their procedure were able to access it.
- The departments were accessible to urgent and emergency scanning requirements 24 hours per day and had fixed opening times for individual modalities from 7.30am until 10.30pm for some services.
- The department had competent staff in post and a local induction for new or temporary staff working in the department.
- Patient outcomes were discussed and radiographer performance was monitored and managed to ensure good quality x-rays and scans were produced. Multidisciplinary working took place with specialties to review scans and x-rays for patients with complex conditions.
- Staff had access to a trust intranet which contained the trust policies and procedures available to staff.
- Staff were aware of their responsibilities in relation to the Mental Capacity Act and obtaining consent from patients and had received training in supporting patients living with dementia.
- At the time of the inspection we did not see evidence that the department was not participating in local clinical audit and was therefore unable to provide evidence that policies and procedures were being adhered to. However, after the initial report was written, the trust sent us evidence to show some clinical audit was being carried out by radiologists.
- Although there was information in the departments about health lifestyle choices, such as diet and, stopping smoking, health promotion was limited other than when patients requested information or when staff deemed patients to be at risk of potential harm.

Diagnostic imaging

- The department was not meeting the 95% target for staff appraisals. Staff we spoke with had generally had opportunity to develop and complete further training.

Is the service caring?

Good

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated caring as good because:

- Patients received treatment that was caring and compassionate from staff who were kind and patient.
- Patient dignity was respected.
- Staff supported patients who were anxious or needed emotional support as a result of their diagnosis.
- Staff made sure to explain information to patients in a way that was easy for them to understand. Patients told us staff did not use medical terminology or jargon when explaining about complications and side effects.

Is the service responsive?

Requires improvement

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated responsive as requires improvement because:

- Patients had long waits to have their x-rays and scans and then further waits to have them reported thus there were delays in reports being sent to patients' GPs and potential delays to patients receiving diagnoses treatments. The position was getting worse when we inspected.
- The department was performing worse than the England average for patients waiting more than six weeks to see a clinician. DPoW was having difficulty meeting performance targets for access to CT, MRI, ultrasound and plain film x-rays for 31 and 62 day wait patients.
- Mechanical breakdown of equipment had impacted on patient access to the department and led to nearly 230 CT or MRI slots being lost.
- Information leaflets were not available in the department for patients requiring an accessible format such as easy read or braille. Of the information leaflets available seven were overdue for review.
- There had been six complaints about the diagnostics and radiology departments at DPoW. These had taken up to 74 days to complete, longer than the trust policy states complaints should be completed by.

However:

- There were processes in place to monitor performance against national and trust targets. These were scrutinised regularly and validated to ensure the most urgent patients were prioritised.
- Patients could be referred for counselling if this was needed.
- Did not attend rates were low.
- There had been 12 compliments received for diagnostic and radiology services at DPoW.

Diagnostic imaging

Is the service well-led?

Requires improvement

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. We rated well-led as requires improvement because:

- The trust had not kept to schedule on its five year vision and strategy. This had a serious impact on the trust's ability to meet demand for scanning services such as CT and MRI.
- Capital expenditure for new equipment had not materialised meaning the department did not have enough equipment that was fit for purpose. The situation of the department had deteriorated and some of these visions had not materialised in to plans of action.
- The senior management team had not carried out any reviews of potential patient harms due to delays in scanning and delays in reporting. Therefore, the trust could not be assured that there had been no patient harm. We were aware of three examples when delays had caused potential harm to patients from January 2017 to March 2018.
- Some staff did not feel encouraged or supported by senior management to progress and felt undervalued for the additional services they provided for their patients. Some staff felt that the senior management team didn't acknowledge or appreciate the additional skills they had.
- The trust had commissioned provision of scanners to manage additional activity needs and equipment breakdowns however these services were not always available overnight thus there was a risk that patients could not access scanners in an emergency

However:

- Staff at DPoW told us they were well managed locally and had confidence in their line managers to address any operational concerns they had in a fair and timely manner.
- There were governance processes in place across the whole of clinical support services, the directorate that managed diagnostics and radiology. Staff were aware of and engaged in the process.
- The trust had a risk register that was updated regularly. Specific risks for DPoW were identified along with waiting list delays, delays in reporting and staffing numbers which were reported as a trust wide risk.
- There was regular data collection and information management which was a key part of the management processes within the directorate. Data was used effectively to performance manage the department.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Scunthorpe General Hospital

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Key facts and figures

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

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

SGH has approximately 310 inpatient beds, 27 day case beds and 18 children's beds. In addition, the hospital provides critical care services, with 13 beds available for intensive care and high dependency patients.

During our inspection of this hospital, we spoke with 119 patients and relatives, 337 staff, reviewed 168 patient records and 51 medicine charts. We observed nursing and medical handovers and an operational site management meeting. We tracked the pathway of 27 patients

Summary of services at Scunthorpe General Hospital

Requires improvement 

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

- We rated safe, effective, responsive and well led as requires improvement and caring and as good.
- At this inspection we saw improvements in some of the hospital's services, but some services had deteriorated since our previous inspection.
- We rated two of the hospital's nine services as good, six as requires improvement and one as inadequate.
- The hospital did not have a systematic or timely approach to quality improvement. We identified concerns in some services that had not been acted upon or changes had not been embedded or sustained from previous inspections.
- The hospital did not always have appropriate numbers of staff to ensure patients received safe care and treatment. The trust had introduced some additional staff and roles and used agency staff to provide cover and mitigate some of the risk to patients.

Summary of findings

- There was limited evidence that service staff had the skills, training and experience to provide the right care and treatment. For example, appraisal rates for a number of staff groups were worse than the trust target and mandatory training rates in seven of the nine services at the hospital were below the trust target of 85%.
- Not all services provided care and treatment based on national guidance. There was variable participation and outcomes in local and national audit and we found action plans did not always address the effectiveness of the care and treatment patients received.
- People could not always access services when they needed it. The total number of patients on outpatient waiting lists had increased since the previous inspection.
- Services did not always manage and investigate concerns and complaints in line with the trust's policy.
- Services at the hospital did all not have a vision, strategy or business plan. There was limited evidence of effective engagement with patients, staff, and the public to plan and manage services.

However:

- The trust had acted on most of the concerns in the Section 29A warning notice that was issued after the inspection in November 2016.
- Staff used appropriate tools for identifying deteriorating patients and patients with sepsis. Audits showed good compliance with these tools and escalation processes. Nurses told us that medical response to patients they escalated was prompt.
- Staff worked together as a team to benefit patients. Doctors, nurses, porters, other healthcare professionals and non-clinical staff supported each other to provide good care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff involved patients and those close to them in decisions about their care and treatment.
- Staff morale appeared to be improving and most staff reported feeling well-supported by their immediate line managers.

Urgent and emergency services

Requires improvement 

Key facts and figures

Scunthorpe General Hospital (SGH) has one accident and emergency department (also known as A&E, emergency department or ED). The emergency department provides a 24-hour, seven-day a week service to the local population.

There were 151,765 attendances from April 2016 to March 2017 at Northern Lincolnshire and Goole NHS Foundation Trust. This included patients who attended Goole minor injury unit. Services at the minor injuries centre at Goole was provided by the trust until April 2018.

From October 2016 to April 2017 the department at SGH had 39,632 attendances at its urgent and emergency care department, an average of 180 patients attending per day. The number of patients attending aged under 16 from April 2017 to March 2018 was 11,764 attendances. The percentage of A&E attendances at this trust that resulted in an admission remained similar from 2015/16 to 2016/17 and was slightly lower than the England average.

The emergency department is a designated trauma unit. However, the most severely injured trauma patients are taken by ambulance or helicopter to the nearest major trauma centre if their condition allows them to travel directly. If not, they are stabilised within the emergency department and either treated or transferred as their condition dictates.

The department had a front door screening and assessment service and was working in partnership with another healthcare provider to provide GP primary and urgent care. Patients would be triaged to either remain in the department or referred to the GP in the department or discharged.

The department was split into several different areas; these included resuscitation, minors, majors and ambulance assessment area. There were three resuscitation bays to be used for patients with more complex and urgent health needs, one bay was specially equipped for children. Minors had six specific assessment rooms to treat patients with minor illnesses including rooms for specialised treatments such as ear, nose and throat. There was an area to treat patients with major injuries and illnesses with 15 cubicles including a mental health assessment room for treatment of patients with mental health issues.

There was a dedicated ambulance entrance for patients arriving by ambulance. There was a rapid assessment area with five bays where patients were assessed before moving to other parts of the department.

We inspected all areas of the department and looked at all five key questions. To make our judgements we spoke with 13 patients, six carers and 30 staff from different disciplines including nurses, doctors, managers, support staff and ambulance staff. We observed daily practice and reviewed 23 sets of records including 10 paediatric records. We tracked 27 patients as they arrived in the department to their first initial assessment. Prior to and following our inspection, we reviewed performance information about the trust and reviewed information provided to us from the trust.

At the last inspection in November 2016, ED was rated overall as inadequate. Safe and well-led were rated as inadequate. Effective, caring and responsive were rated as requires improvement. Following the inspection, we issued the trust with a Section 29A warning notice which stated that the quality of health care provided by the trust required significant improvement specifically in ED and one other service. There were significant issues relating to ED:

- Staff shortages and a lack of escalation processes were putting patients at risk.

Urgent and emergency services

- The lack of patient assessments and / or escalation of patients identified as being at risk causing patients' safety to be compromised.
- There was insufficient management oversight and governance of the identified risks.

We undertook an unannounced visit in June 2017 to follow up on the actions the trust told us they had taken in relation to the Section 29A warning notice issued in January 2017. We found that the trust had not taken sufficient, timely action to address all our concerns.

Our inspection in May 2018 was announced (staff knew we were coming).

Summary of this service

Our rating of this service improved. We rated it as requires improvement because:

- There were no registered sick children's nurses (RSCN) in the department. No staff had completed any university accredited modules or further training modules in paediatric care. There was no ownership of the risks in relation to paediatric care, it was not identified on the risk register and the department relied on the paediatric department supporting them with issues. Paediatric immediate life support training did not meet the trust target of 85% and we were not assured that staff were assigned on specific shifts that had required training.
- The majority of mandatory training figures for both medical and nursing staff did not meet the trust's target of 85%. Medical staff and nursing staff both only met the trust target in one of the ten mandatory training courses. For safeguarding training, medical staff met the trust target for two out of eight courses, nursing staff did not meet the target for any of the courses.
- Safeguarding information was not always recorded which meant that we were unsure if information or risks had been identified.
- There were vacancies for medical staffing which meant that locums covered many shifts, however some gaps were left unfilled.
- Some patient pathways had not been reviewed and remained out of date, these included pathways that we raised at our inspection in November 2016. Patient group directions (PGD) that were due to be reviewed in 2017 had been extended to August 2018 before they would be reviewed.
- Appraisal rates were not met for any of the staff groups.
- RCEM audits showed that the trust failed to meet the 100% national standard set apart from one standard in the procedural sedation in adults.
- We reviewed six RCEM audits and found out of 33 standards: the trust was in the lower UK quartile for 12 standards.
- The trust's unplanned re-attendance rate to A&E within seven days was between 9% and 10% and consistently worse than the national standard of 5% average in 11 out of 12 months.
- Further work was required to embed strategies that would improve flow such as working with specialists across the hospital to support ED but the pace of arranging and changing practice was not embedded.
- The trust was not meeting their targets to close complaints within the allocated timeframes. For example, 37% were closed within 30 days and 47% within 45 days. For complex complaints, 77% were closed within the time frame of 60 days.

Urgent and emergency services

- Although the department now audited the level of care they provided to patients' further improvements were required to increase compliance to 100%.
- There was limited patient and staff engagement. Staff were not involved in trust's initiatives to develop or celebrate success in the department.

However:

- The trust had acted on the concerns raised in the Section 29A warning notice that was issued after the inspection in November 2016. This included changes and improvements to patient's record keeping. Risk assessments had been completed and monthly dashboards were completed to provide assurances that these were done. There had been an increase in healthcare assistants to provide regular care rounds to patients to support them with their needs.
- There were improvements in how patients were provided with nutrition, hydration and pain relief. A monthly dashboard provided the department with assurances that patient's needs were being met.
- There were improvements in the time patients waited from arrival to their initial assessment with the introduction of streaming and triaging patients within the department. This had reduced from 30 minutes to 15 minutes to be assessed. There had also been a reduction with turnaround times over 30 minutes since July 2017 for ambulance journeys.
- We reviewed six RCEM audits and found out of 31 standards, the trust was in the upper UK quartile for six standards. The trust was similar too other hospitals (between upper and lower UK quartiles) for 15 standards.
- We observed that wards had effective approaches to multidisciplinary working. Staff described good working relationships between consultants, nurses and allied health professional staff.
- Patients provided feedback and told us that staff were caring and provided compassionate care. They felt involved in making decisions with their care and treatment. Privacy and dignity was observed, and patients were supported with their emotional needs.
- The trust had applied measures to manage the access and flow in the department. These included regular meetings and escalation processes to support the department. There had been an introduction of streaming and triage staff that triaged patients. There had been reductions in the time to treat and patients waiting from the decision to admit until being admitted. There were improvements towards the four-hour target which was better than the England average from October 2017 to January 2018.
- The majority of staff enjoyed working in the department and felt listened to. Senior management spoke positively about their staff and felt proud of their team. Staff supported each other and worked well together.
- A shift lead was in charge to monitor and review ongoing care in the department. Various mechanisms had been implemented to provide assurances that there was an oversight of the issues in the department. These included walk rounds, board rounds, safety huddles and quality meetings.

Is the service safe?

Requires improvement 

Our rating of safe improved. We rated it as requires improvement because:

- There were no registered sick children's nurses therefore there was no cover in the department. This did not meet the standards set in the Intercollegiate Emergency Standards 2012. There was no separate paediatric department and children used the same facilities as adult patients.

Urgent and emergency services

- Paediatric immediate life support (PILS) training provides staff with more advanced paediatric skills in resuscitation. We saw that 62% of staff had completed the course meaning 38% did not have a current PILS qualification to provide up to date and evidence-based training. Five staff had completed a two-day European Paediatric Life Support course which was validated for four years.
- There were several medical vacancies which as a result left gaps within the rotas. Some of these gaps were covered by locum staff. There was not consistent cover by the consultants between the agreed hours of 8am to 10pm. This did not meet the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day.
- Mandatory training figures did not meet the trust's target for 18 courses out of 20 for both medical and nursing staff. Compliance rates for nursing staff training ranged between 48.1% for manual handling (people) to 83% for equality and diversity. The compliance rates for medical staff were well below the trust's target of 85% with information governance and equality and diversity at 53% the nearest to the set compliance rate.
- Safeguarding information was not consistently recorded within the patient's record. Nursing staff were not achieving the trust target of 85% for any of the four safeguarding training courses. Medical staff were achieving compliance for two courses – safeguarding children levels one and two.
- There were some vacancies for registered nurses which had impacted on the ability to cover the shifts with the required amount. Many shifts were covered through bank and agency staff.

However:

- We saw some improvements in the standard of cleanliness and adherence to hygiene procedures. Checklist and audits had been introduced to ensure standards were met.
- We saw improvements in the monitoring of resuscitation equipment which identified that regular checks were completed.
- Staff recognised incidents and knew how to report them. Managers carried out investigations and shared lessons learned during the daily huddle, through email and on the teaching and training board.
- The introduction of the streaming nurse had improved and reduced the time from arrival to initial assessment. This had improved from 30 minutes down to 15 minutes, although the median time was 15 minutes in comparison to the England average of nine minutes. There had also been a reduction with the amount of ambulance journeys with a turnaround time of over 30 minutes since July 2017.
- The trust had improved record keeping. The patient records had been reconfigured and we saw improvements; risk assessments, care rounds and National Early Warning Score (NEWS) scores were recorded. Mental Health risk assessments were completed which reviewed a patient's risk level and actions required.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The department did not have any registered sick children's nurses (RSCN) who were specifically trained in managing and caring for children. No staff within the department had completed further training in how to manage children conditions and illnesses.

- Some pathways had not been reviewed and updated that were identified at our previous inspection in November 2016. The patient group directions (PGD) that staff used to administer medicines were due to be reviewed in 2017 however they had been extended to August 2018 before they would be reviewed.
- Appraisal rates identified that they were not meeting the trust's target of 95%. Reports identified that 71.8% of nursing staff, 81.8% support staff and 58.3% medical staff received an appraisal.
- RCEM audits showed that the trust failed to meet the 100% national standard set apart from one standard in the procedural sedation in adults.
- We reviewed six RCEM audits and found out of 33 standards:
  - the trust was in the lower UK quartile for 12 standards.
  - the trust was similar to other hospitals (between upper and lower UK quartiles) for 15 standards
- In the severe sepsis and septic shock RCEM audit the hospital was worse than other hospitals (lower UK quartile) for six out of eight standards. In the consultant sign off audit the hospital was worse than other hospitals (lower UK quartile) for two out of four standards.
- Although we saw improvements in recording patients' pain control, further improvements were required to increase the compliance. Pain control was recorded on the monthly ED dashboards which showed in April 2018 that 89% had a pain score completed; with 82% receiving analgesia timely. In records we reviewed we saw that 57% contained a pain score.
- The trust's unplanned re-attendance rate to A&E within seven days was between 9% and 10% and consistently worse than the national standard of 5% average in 11 out of 12 months.

However:

- We reviewed six RCEM audits and found out of 31 standards: - the trust was in the upper UK quartile for six standards.
- In the procedural sedation in adults the department met the national standard of 100% of procedural sedations taking place in a resuscitation room or a room with dedicated resuscitation facilities.
- Patients were regularly offered food and drinks. Hydration stations had been introduced for patients and family members. Audits were completed on identifying whether patients had been offered food and drink with positive findings.
- We observed the staff working together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care. We observed effective communication between nursing and medical teams.
- Staff we spoke with demonstrated a good knowledge of the Mental Capacity Act in relation to their role and obtaining consent from patients. 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.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good because:

- Processes such as care rounds had been implemented which ensured that patients basic care needs were being met. Staff responded compassionately to patient's pain, discomfort, and emotional distress in a timely and appropriate way. Patients felt they were treated with dignity and respect.
- In relation to patients who attended with mental health problems we observed staff demonstrating a non-judgemental attitude towards patients and described assessing patients' needs on an individual basis which would include both mental and physical health.
- We spoke with 13 patients and six relatives who told us that they found staff to be caring, they were kept informed, they were comfortable and always felt respected.
- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- Patients told us staff ensured they understood medical terminology and took time to explain conditions and treatments. Patients who used the service felt involved in planning their care, making choices and informed decisions about their care and treatment. We observed staff communicating in a way that people could understand and was appropriate and respectful.

However:

- Results from the Friends and Family Test were slightly worse than the England average although there had been some improvement seen in score since August 2017.

Is the service responsive?

Good 

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

- Services were planned and provided in a way that met the needs of local people. The trust worked with commissioners, external providers and local authorities to improve the patient's pathway and experience.
- Patient's individual needs were met. Systems were in place for patients living with dementia and learning difficulties to support them whilst in the department. Specialist services were available for staff to access and attend the department, these included learning difficulties, diabetic and dementia link nurses.
- The trust had applied measures to manage the access and flow in the department. The introduction of streaming and triage staff had ensured that patients were seen in the relevant areas by the most appropriate clinician. We saw that there had been reductions in the time to treat and patients waiting from the decision to admit until being admitted. There were improvements towards the four-hour target which was better than the England average from October 2017 to January 2018.
- Regular operational meetings were held to understand the bed situation, enable planning for expected admissions and discharge and to ensure patient flow throughout the hospital was timely. There was an escalation policy in place which allowed medical staff to make autonomous decisions in managing patient capacity within the department. This included emergency department consultants admitting patients to speciality areas.
- The department had a complaints response process that addressed both formal and informal complaints. Patients and relatives, we spoke with knew how to complain although none of the people we spoke with complained about the department. Complaints were investigated, and learning was shared with staff.

However:

- There was no screen or signage to inform patients how long the wait was in the waiting area.
- Further work was required to embed strategies that would improve flow such as working with specialities across the hospital to support ED.
- The trust was not meeting their targets to close complaints within the allocated timeframes. For example, 37% were closed within 30 days and 47% within 45 days. For complex complaints, 77% were closed within the time frame of 60 days.

Is the service well-led?

Requires improvement 

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

- There were no plans in place in how to increase registered sick children's nurses staffing numbers. No staff had completed further training to mitigate the risk as there were no RSCN staff in place. Levels of resuscitation training for paediatrics were not at the required level.
- There was limited oversight regarding paediatrics at a local level within the department. The risk register did not highlight any issues identified with paediatrics and how to minimise the risk and staff relied on the paediatric department supporting them. Rotas were not configured to assure that on each shift there was suitable staff with paediatric resuscitation training.
- Although the department now audited the level of care they provided to patients' further improvements were required to increase compliance to 100%.
- Senior managers had identified that the trust needed to work more cohesively with other specialities to support ED staff and reduce the length of stay for patients, but the pace of arranging and changing practice was not embedded.
- There was limited patient and staff engagement. Staff were not involved in trust's initiatives to develop or celebrate success in the department.

However:

- The trust had acted on the concerns in the Section 29A warning notice that was issued after the inspection in November 2016. In particular, the lack of patient's risk assessments and escalation of patients at risk.
- A shift lead was in charge to monitor and review ongoing care in the department. Various mechanisms had been implemented to provide assurances that there was an oversight of the issues in the department. These included walk rounds, board rounds, safety huddles and quality meetings.
- The majority of staff enjoyed working in the department and felt listened to. Senior management spoke positively about their staff and felt proud of their team. Staff supported each other and worked well together.
- Information technology systems were in place to monitor and improve the quality of care. These included the use of a monthly ED dashboard to review and monitor nursing care records and the live ED system that allowed up to date information on the current demands of the department

Areas for improvement

We found areas for improvement in this section. See the Areas for Improvement section above.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

Scunthorpe General Hospital is part of Northern Lincolnshire and Goole NHS Foundation Trust providing medical care to people in Grimsby and the surrounding area. Three sites across the trust provide medical care services, these were Diana, Princess of Wales (DPoW), Scunthorpe General Hospital (SGH) and Goole and District Hospital (GDH). 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. There were 195 beds located within eleven wards.

The trust had 46,141 medical admissions from December 2016 to November 2017. Emergency admissions accounted for 21,578 (46.7%), 675 (1.5%) were elective, and the remaining 23,888 (51.8%) were day case.

Admissions for the top three medical specialties were:

- General medicine – 18,033
- Gastroenterology – 7,229
- Medical oncology – 7,008

The medical wards / areas at SGH were:

- Stroke Unit (SSRU) which included a hyper acute stroke unit.
- Planned investigations unit (PIU)
- Ward 2 – general medicine
- Ward 16 – general medicine
- Ward 17 – general medicine
- Ward 18 – haematology and oncology
- Ward 22 - respiratory medicine
- Ward 23 - gastroenterology
- Ward 24 - cardiology
- Coronary Care Unit (CCU) – cardiology
- Ambulatory care unit
- Clinical Decisions Unit (CDU) – acute general medicine
-

The hospital also had a cardiac catheter lab, an endoscopy unit and a discharge lounge on site that were included as part of the medical service inspection.

We inspected the medical service 8–11 May 2018, as part of an announced comprehensive inspection of the whole trust due to it being in special measures. We also carried out an unannounced visit on 23 May 2018. CQC previously inspected the medical service at this hospital in October 2016 and rated the service as 'requires improvement' overall, with 'good' for caring and 'requires improvement' for safe, effective, responsive and well-led.

Medical care (including older people's care)

We visited all medical wards / areas and observed care being delivered. Before the inspection, we reviewed performance information from, and about the trust.

During the inspection we looked at 40 patient records (a mixture of medical, nursing and therapy notes), 14 prescription charts, spoke with 27 patients and relatives, and more than 70 staff including doctors, nurses, therapists, healthcare assistants and support staff, nursing and operational managers and student nurses. We also attended medical and nursing handovers and operational site meetings.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- We had concerns about the safety of medical care services with regard to; the number of serious incidents, some issues with medicines management, compliance with mandatory training particularly among medical staff and the number of medical staffing vacancies which was impacting on cover arrangements and support and training of junior doctors.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England average and RTT performance had steadily deteriorated since 2015.
- Patients were not reviewed daily by a senior clinician and were not always reviewed by their specialty consultant / team in a timely way.
- There continued to be issues with delayed transfers of care, outlying patients, bed moves at night and mixed sex-accommodation breaches, although the trust was working on these and there had been some signs of improvement.
- There was no overarching, fully developed strategy or business plan for the medical service for 2018/2019. We were not assured that risks on the risk register were being actively managed or effectively overseen and there were still areas where junior nursing staff felt bullied and intimidated by middle managers.

However:

- Nurse staffing had improved and there were escalation processes in place to move staff to where they were needed most, based on ongoing risk assessments. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The endoscopy service was achieving two-week and urgent standards for investigation and had a clear plan to enable it to re-apply for JAG accreditation in October 2018 and it now had a seven-day, 24-hour, gastrointestinal bleed rota in place. The FEAST team had been successful in avoiding unnecessary admissions for frail elderly people and the ambulatory care unit was developing its services and had implemented some outreach to patients in their own home.
- Staff cared for patients with compassion and involved them in decisions about their care. Feedback from patients confirmed that staff treated them well and with kindness.
- There had been changes to the senior management team and they had clear ideas and early plans for how the services needed to be developed. They were aware of the issues regarding pockets of bullying and had started to act to improve this situation. Staff spoke highly of the new Associate Chief Nurse and staff morale appeared to have improved since the last inspection and their appointments.

Medical care (including older people's care)

Is the service safe?

Requires improvement  

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

- We were concerned about the number of serious incidents within the medical service. Feedback to staff and shared learning from serious incidents was evident but ward managers felt they could use routine feedback from other incidents such as medicine incidents to learn from themes and trends. However, incidents were reported, and staff were open and honest with patients when things went wrong.
- We had some concerns regarding medicines management in relation to; some gaps in signing for receipt and second signature for administration of controlled drugs, nurses not always performing a second check before giving discharge medicines to patients, a lack of pharmacy support due to vacancies which meant there was little capacity to support or quality assure discharge medicines. Pharmacists felt that this carried a risk of unrecognised transcribing / labelling errors and a potential for under-reporting of this type of medicine related incidents.
- Compliance with mandatory training was below the trust target for nursing staff in seven out of ten modules and medical staff compliance was very poor with only two modules having a compliance of over 50%. Safeguarding training compliance for medical staff was 62% and 64% for the different modules.
- This hospital had a medical vacancy rate of 30% at the time of inspection. There was still minimal medical cover at night, which was identified as a concern at the last inspection, with one registrar and two junior doctors covering the stroke unit, the clinical decisions unit and all medical wards. Medical and nursing staff felt that this was potentially unsafe. The local deanery was not placing cardiology junior doctors at the trust as there had been a lack of support and teaching available due to consultant pressures.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Nursing staff compliance with training was at the trust target of 85%.
- The nurse staff fill rate was around 95% for this hospital and although there were still registered nurse vacancies on the medical wards (22% vacancy rate), both the planned and actual numbers of registered staff had gone up. Escalation processes were in place to move staff to where they were needed most, and staff felt the wards were better staffed than the previous year. Staff also reported that staff movement had reduced.
- Staff used appropriate tools for identifying deteriorating patients and patients with sepsis and audits showed good compliance with these tools and escalation processes. Nurses told us that medical response to escalated patients was prompt.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good because:

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

- Although the endoscopy unit had not yet re-applied for JAG (Joint Advisory Group on Gastrointestinal endoscopy) accreditation they had achieved all criteria other than reduction of the waiting list. There was a business plan being submitted to achieve the waiting list reduction to enable the unit to re-apply in October 2018. The unit had a good system in place to ensure two week wait targets were met and urgent patients were seen quickly.
- The trust had introduced a seven-day, 24-hour, gastrointestinal bleed rota, which had now been embedded.
- Staff worked together as a team to benefit patients. 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 (MCA) and Deprivation of Liberty Safeguards (DoLS) and acted in accordance with the act. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care
- There were clinical skills educators employed by the trust to provide education and training to staff in the clinical and ward areas. Feedback from newly qualified nurses regarding training and support from the clinical skills team was excellent.

However:

- There were mixed results in national audits. Whilst there was a lower risk of readmission and good performance in the Sentinel Stroke National Audit Programme, performance in the Heart Failure Audit and Lung Cancer Audit 2017 was mixed and the Myocardial Ischaemia National Audit Project and National Audit of Inpatient Falls 2017 were poor.
- From April 2017 to January 2018, 63.4% of staff within medical care services at this hospital had received an appraisal compared to a trust target of 95%. This was similar to the previous year.
- Not all medical patients received a senior medical review every day, particularly at weekends.
- Compliance with MCA and DoLS training was poor among medical staff.

Is the service caring?

Good  

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. The response rate for the friends and family test was 38% which was better than the England average. From December 2016 to November 2017 most medical wards had consistently high recommendation rates between 90-100%.
- We saw staff treating patients with respect and preserving their dignity, sometimes in very difficult circumstances. Patients felt staff were approachable and they could "have a laugh with them."
- We saw, and patients told us that staff provided emotional support to patients to minimise their distress. We also saw staff caring for each other and providing emotional support.
- Staff involved patients and those close to them in decisions about their care and treatment. We heard patients being given clear instructions in a caring manner and saw examples of where passwords had been set up for relatives to be given information over the phone (where patient consent had been given).

Medical care (including older people's care)

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The trust's referral to treatment time (RTT) for admitted pathways for medical services was consistently worse than the England average from January 2017 to December 2017. The position for December 2017 had deteriorated each year since 2015.
- Patient flow through the hospital remained an issue with a significant number of patients cared for on non-medical or non-speciality wards (outliers). A buddy ward system was in place however, there were still some issues with medical staff reviewing patients in a timely way.
- From February 2017 to January 2018 there were 586 reported delayed discharges, however, this was improving with the numbers falling from 84 in month one to around 40 in month 12.
- Trust data showed that from January 2017 to December 2017 there were 371 patients moved at night at SGH, usually ranging between 25 and 35 each month, with one peak of 51 patients moved at night during March 2017
- There were 68 mixed sex accommodation breaches in the medical service at SGH from February 2017 to January 2018, 63 of these were on the respiratory ward.

However:

- The endoscopy team had worked hard to reduce the number of two-week breaches and this had now been resolved. Staff were confident they could reduce the waiting list completely, to be able to apply for re-accreditation in October 2018.
- The average length of stay for medical patients was lower than the England average for both elective and non-elective admissions.
- The service took account of patients' individual needs and we saw some good examples of where staff had made special arrangements to meet an individual patient's needs.
- The frail elderly assessment team (FEAST) had been extremely successful in avoiding unnecessary admissions for frail elderly people and the ambulatory care unit was developing its services and had implemented some outreach to patients in their own home.

Is the service well-led?

Requires improvement ➔➔

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

- The trust was in the middle of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the medical service for 2018/2019. However, services were developing plans which would feed into the new strategy.
- Two out of three of the senior leaders of the medical service, the divisional clinical director (DCD) and the associate chief nurse (ACN) were relatively new in post and had not had time to fully develop the services and relationships with staff as they wished. However, they had clear ideas and early plans for how the services needed to be developed.

- Risks on the risk register were not being actively managed or effectively overseen as many risks had little information in the way of updates indicating that the reviewer was unaware of any progress.
- There were still areas where junior nursing staff felt bullied and intimidated by middle managers, and although the new senior leadership team were aware of this and had started to act to improve this situation, some staff were unaware of what actions were being taken.

However:

- There was a clear leadership and governance structure and staff knew how to escalate issues and risks. All wards had a ward manager who were supported by operational and quality matrons and the ACN. Staff spoke highly of the ACN, staff said they were accessible, approachable and listened to them. Staff morale appeared to have improved and staff reported feeling well-supported by their immediate line managers.
- The senior leaders promoted the idea of success and quality of care being dependant on engaging and caring for staff. The ACN and DCD had taken early steps to ensure staff were engaged in improving services. They were aware that there was a feeling among some staff that there were still pockets of bullying and intimidation and they were actively trying to identify specific areas of concern and act to improve this.
- The service engaged with patients and stakeholders to plan and improve services and there were examples of innovation to improve services.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding Practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

Surgery

Requires improvement 

Key facts and figures

Surgical services at Northern Lincolnshire and Goole NHS Foundation Trust provides elective and emergency surgical care to patients.

The hospital has five surgical wards and eight operating theatres. The surgery directorate provides acute, elective and day case surgery covering 10 surgical specialities; including breast, colorectal, ear, nose and throat, general surgery, upper gastrointestinal, oral-maxillo facial, orthopaedics, trauma and urology.

The hospital has 87 inpatient surgical beds, including four high observation beds.

The trust had 43,026 surgical admissions from December 2016 to November 2017. Emergency admissions accounted for 9, 415 (21.9%), 3,685 (8.6%) were day cases and the remaining 29, 926 (69.6%) were elective admissions.

(*Source: Hospital Episodes Statistics*)

We inspected the surgical service on 8-11 May 2018 as part of an announced comprehensive inspection of the whole trust due to it being in special measures.

The trust was last inspected in October 2016, where all five domains in surgery were inspected and an overall rating of requires improvement was given. Well led was rated as inadequate, safe, effective, responsive were all rated as requires improvement and caring was rated as good.

The main areas of concern from the last inspection and the areas in surgery where the trust was told to improve were:

- The trust must ensure that service risk registers are regularly reviewed, updated and include all relevant risks to the service.
- The trust must ensure that there are, at all times, sufficient number (including junior doctors) of suitably skilled, qualified and experience staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must monitor and address mixed sex accommodation breaches.
- The trust must ensure that, following serious incidents or never events, root cause and lessons learned are identified and shared with staff.
- The trust must ensure that effective processes are in place to enable access to theatres out of hours, and that all cases are clinically prioritised appropriately.
- The trust must ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently within surgical services.
- The trust must ensure the proper and safe management of medicines including: ensuring that fridge temperatures used for the storage of medicines are checked on a daily basis in line with the trust's policy.
- 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 (2015).

Surgery

- The trust must ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies.

We also said that the trust should:

- Ensure that patients are assessed for delirium in line with national guidance.
- Review the formal feedback process in place to collect patient or relative feedback.
- Ensure that staff complete Mental Capacity Act training.
- Take steps to improve its staff and public engagement activities.
- Ensure that resuscitation equipment is regularly checked and tested consistently and in line with trust policy.
- Ensure that Patient Group Directives for nursing staff are completed and up to date.

During this inspection, we visited the surgical wards, operating theatres and recovery areas and day surgery unit. We spoke with 27 patients and 54 members of staff. We observed staff delivering care and reviewed 22 sets of patient records and prescription charts. We also reviewed a further 40 sets of records looking specifically at patients having orthopaedic surgery. We reviewed trust policies and performance information, from and about the trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- From our observations it was apparent that effective processes were not in place to enable access to theatres out of hours for patients requiring surgery for neck of femur fractures.
- The directorate did not have a stable management structure in place. The divisional clinical director was new in post, the divisional general manager was in an interim role. The divisional head of nursing was the only member of the team that remained in post since the last inspection. This had an impact on the decision making, governance and oversight of the issues within surgery.
- The theatre department had a number of areas which required refurbishment, we saw damaged doors showing bare wood and chipped, cracked plasterwork. Areas used for theatre storage had evidence of water damage, poor maintenance and damaged windows which did not provide assurance of compliance with health building note (HBN) 26 Facilities for surgical procedures or HBN 00-09 Infection control in the built environment. Following the inspection, the trust took action to improve the facilities in this area.
- We saw variable performance in national audits. Action plans we reviewed did not always address issues identified within the reports and actions had not had an impact on overall performance outcomes.
- The trust was not meeting the national performance standards for treatment or cancer standards. The trust referral to treatment time was consistently worse than the England average, fluctuating around 65%. Four out of six surgical specialities were worse than the England average performance.
- We had previously highlighted pre-assessment services required improvement in relation to clinical pathways, clinical cancellations of patients and competence of staff. At this inspection we did see some improvements in this service, however this needed more pace and a further period of embedding to provide assurance that the service was effective and responsive to clinical needs.

Surgery

- There were shortages of nursing and medical staff; these shortages were evident in the majority of surgical areas. There was also high levels of bank and agency staff in use and some surgical areas had a low number of substantive permanent staff.
- The trust was in the process of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the surgical service for 2018/2019.
- Appraisal rates for staff were worse than the trust target. Seventy one percent of nursing staff had received an appraisal which was worse than the target of 95%.
- Policies, procedures and clinical decision making were not always based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE).

However:

- From our observations it was apparent that the five steps to safer surgery checklist, was now embedded as a routine part of the surgical pathway.
- The majority of patients we spoke with were positive about the care and experience they had received.
- The service had systems in place for reporting, monitoring and learning from incidents. Staff we spoke with knew how to report incidents.
- We found wards and departments we visited clean and tidy, and we saw ward cleanliness scores displayed in public corridors.

Is the service safe?

Requires improvement 

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

- The theatre department had a number of areas which required refurbishment, we saw damaged doors showing bare wood and chipped, cracked plasterwork. Areas used for theatre storage had evidence of water damage, poor maintenance and damaged windows which did not provide assurance of compliance with health building note HBN 26 Facilities for surgical procedures or HBN 00-09 Infection control in the built environment.
- We had previously highlighted pre-assessment services required improvement in relation to clinical pathways, clinical cancellations of patients and competence of staff. At this inspection we did see some improvements, however we saw that some patients care, and treatment were still being delayed because of in-effective pre-assessment pathways. The changes needed more pace and a further period of embedding to provide assurance that the service was effective and responsive to clinical needs.
- There were shortages of nursing and medical staff; these shortages were evident in the majority of surgical areas. There was also high levels of bank and agency staff in use and some surgical areas had a low number of substantive permanent staff.
- Overall mandatory training compliance for medical and dental staff was 57.6%, which was worse than the trust target off 85%. This figure had decreased significantly from the previous inspection.
- Of the safeguarding children's courses delivered by the trust twenty-four medical and dental staff and 25 nursing staff eligible for level two training had not completed it.

However:

Surgery

- At the previous inspection, we had highlighted that the five steps to safer surgery including the World Health Organisation (WHO) checklist, was not used effectively. During this inspection we saw improved practice and from our observations it was clear that the checklist was embedded as a routine part of the surgical pathway.
- We saw improvements in the process to identify patients who were deteriorating. We saw that staff had completed records correctly and saw evidence of appropriate escalation.
- We found wards and departments we visited clean and tidy, and we saw ward cleanliness scores displayed in public corridors.
- The service had systems in place for reporting, monitoring and learning from incidents. Staff we spoke with knew how to report incidents.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- At the previous inspection, we highlighted that there was not an effective process to enable access to theatres and ensure that all cases were clinically prioritised appropriately. From our observations at this inspection it was apparent that this had not improved for patients requiring surgery for neck of femur fractures. We saw a deteriorating position in relation to the proportion of patients having surgery on the day of or day after admission. This was 53.5% in 2017, which was worse than the national standard of 85% and worse than the 2016 figure of 62.5%.
- We saw variable performance in national audits with some criterion performing worse than the national rate, some within the expected range and some performing better than expected. Action plans we reviewed addressed this issue identified within the reports but had not had an impact on overall performance outcomes.
- Food and fluid charts were not always completed accurately. Staff did not total the daily intake and output on all fluid balance charts we reviewed.
- Records we reviewed, showed that on four out of four occasions patients had been fasted for too long pre-operatively, for example between 12-14 hours prior to surgery. Audits on patient fasting times were not carried out.
- Appraisal rates for staff were worse than the trust target. Seventy one percent of nursing staff had received an appraisal which was worse than the target of 95%.
- Policies, procedures and clinical decision making were not always based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE).

However:

- Within surgery patients had lower than expected risk of readmission for both elective and non-elective admissions when compared to the England averages.
- Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.
- Staff we spoke with said that they had good access to all information required to deliver services to patients.

Surgery

Is the service caring?

Good ➔➔

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

- The majority of patients we spoke with described their care in positive terms. Patients we spoke with reported staff were caring and compassionate.
- We observed privacy and dignity being maintained for patients receiving care.
- We saw staff provide emotional support and reassurance to patients.
- The trust had multi- faith chaplaincy service and bereavement services, patients also had access to specialist nurses for further information and support when required.
- From speaking with patients and their relatives and reviewing care records, we found evidence of their involvement in care planning and delivery.

However:

- Friends and family test response rates for the surgical directorate were worse at 23% than the England average of 29%.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Overall the percentage of cancelled operations at the trust was worse than the England average from January 2016 to December 2017.
- The trust was not meeting the national performance standards for treatment or cancer standards. The trust referral to treatment time was consistently worse than the England average, fluctuating around 65%. Four out of six surgical specialities were worse than the England average performance.
- The directorate did not respond to patient complaints within the trust timescale of 30 working days. At the time of the inspection the directorate took an average of 48 working days to close a complaint. Complex complaints had a target for closure of 60 working days and only 68% of all complaints were closed within this timescale.
- The number of medical outliers in surgical beds reduced the number available to deliver surgical services and led to increases in waiting times for surgical procedures.
- Trauma and orthopaedics did not have access to responsive services seven days a week, this includes access to theatres and rehabilitation support services to enable timely access to physiotherapy and occupational therapy staff.

However:

- The hospital performance for elective and non-elective length of stay for surgical patients was better than or similar to the England average.

Surgery

- From December 2016 to December 2017 the percentage of patients whose operation was cancelled and were not treated within 28 days had increased. However, in the most recent quarter (Q3 2017/18) 5% of patients whose operation was cancelled were not treated within 28 days this was better than the England average (8%).

Is the service well-led?

Inadequate  

Our rating of well-led stayed the same. We rated it as inadequate because:

- The directorate should have moved with more pace to address issues from the previous inspection, particularly early access to theatres for patients with neck of femur fractures and pre-assessment of surgical patients.
- The directorate did not have a stable management structure in place. The divisional clinical director was new in post, the divisional general manager was in an interim role. The divisional head of nursing was the only member of the team that remained in post since the last inspection. This had an impact on the decision making, pace of change, governance and oversight of the issues within surgery.
- The governance structure required strengthening to monitor performance and risks. This meant that the directorate did not have the recognition and oversight of all the risks to escalate issues to the board in a timely way.
- The trust was in the process of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the surgical service for 2018/2019.
- Directorate action plans did not always address all issues of poor performance highlighted within national audits, and in some cases performance was getting worse despite an action plan being in place. Action plans did not always reflect improvements seen at the Diana Princess of Wales hospital and ensure these were mirrored at SGH.
- Senior nursing staff we spoke with highlighted concerns with a breakdown in relationships between site management teams and wards in relation to the admission of medical patients to surgical wards or the movement of surgical patients.
- The trust was not meeting the national performance standards for treatment or cancer standards, we had highlighted this at previous inspections, but performance continued to be worse than the England average performance.
- Policies, procedures and clinical decision making were not always based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence.

However:

- Staff morale was variable, it had improved slightly in some areas we visited. Staff we spoke with said that they felt supported by the senior leaders within surgery and felt able to escalate concerns.
- We were assured the trust had taken measures to address some of the issues raised at the last inspection but at the time of this inspection we were unable to see the impact of the changes.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Critical care

Requires improvement  

Key facts and figures

Northern Lincolnshire and Goole NHS foundation trust has two critical care units. Scunthorpe General Hospital has a combined intensive care unit (ICU) and high dependency unit (HDU). This provides level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care to adult patients.

There is a total of eight beds in the unit, comprising of two single rooms and a bay containing six beds. The unit is staffed to care for a maximum of seven level three patients, or six level three patients and two level two patients.

Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2017 and 31 December 2017 at this site, there were 316 admissions with an average age of 63 years. Seventy four percent of admissions were non-surgical, 12% were planned surgical admissions and 14% were emergency surgical admissions. The average length of stay on the unit was two days.

A critical care outreach team provided a supportive role to the wards medical and nursing staff when caring for deteriorating patients and support to patients discharged from critical care. The team was available seven days a week. A recent change in their hours allows them to provide 12-hour cover during the day. Cover at night is provided by the hospital at night team.

The critical care service is part of the East Yorkshire and Humberside Critical Care Network.

The unit did not accept paediatric admissions. The anaesthetist or consultants would attend in an emergency and stabilise the patient until a bed was available on the neonatal ICU or the dedicated intensive care transport service for children arrived. The unit had an inter hospital transfer policy which was in line with the critical care network and national guidelines.

Our inspection was announced as part of an announced comprehensive inspection of the whole trust due to it being in special measures. At the last inspection the responsive domain was rated requires improvement. The domains of safe, effective, caring and well led were rated good. We re-inspected all five key questions during this inspection.

During this inspection we visited the intensive care unit. We spoke with four relatives and 23 members of staff. We observed staff delivering care, looked at eight patient records and five prescription 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.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The responsive domain improved and was rated as good, with caring and well led, however we rated safe and effective as requires improvement.
- Medical staffing was not in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards and a lack of administrative support was impacting on nurse staffing.
- There were issues in accessing support from the mental health team and microbiology input was limited. Multidisciplinary attendance at wards rounds was variable.

Critical care

- We were not assured around the assessment of mental capacity; however, we saw high levels of compliance for Mental Capacity Act training.
- We lacked assurance over the checking process for the transfer bag and staffs' awareness of fire evacuation procedures.
- Some outcomes in the ICNARC data were worse when compared to similar units.

However:

- Mandatory training compliance was good for medical and nursing staff and the number of staff with a post registration certificate in critical care exceeded GPICS standards.
- The systems and processes in place for management of patient records and the assessment of patient risks were reliable and followed national guidance.
- Care was evidence based and feedback from patients and relatives was positive. The privacy and dignity of patients was maintained, and care was compassionate.
- The number of non-clinical transfers had reduced and there had been a re-launch of patient's diaries.
- There was a vision and strategy for the service. There was clear medical and nursing leadership with an understanding of the risks and challenges to the service.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- We found the same situation with regards to medical staffing as at the previous inspection, in that it was not in line with GPICS standards as consultants had other areas of responsibility when on call and the rota did not provide continuity of care for patients.
- Whilst nurse staffing levels were in line with GPICS standards, the lack of any administrative support on the unit did impact on nursing responsibilities. We observed how staff were having to regularly break off to answer the phone.
- We identified from speaking with staff there were problems with mental health support being available to attend the unit. We were provided with examples when this support was needed but not provided.
- We were concerned that staff were not aware of the fire evacuation strategy specific to the unit. There had been no recent scenario training with staff to test the evacuation plans. We also found one of the escape corridors was obstructed with trollies.
- We found there was no contents list or robust checking process in place for the equipment bag used for patient transfers.
- The number of unit acquired infections in blood was higher when compared to similar units and had risen since the previous inspection from 2.5 to 3.9, with similar units having 1.4 (unit acquired infections for each 1000 patient bed days).

However:

- We found the eight patient records we reviewed had been completed to a good standard in line with trust and professional standards; this was an improvement since the previous inspection.

Critical care

- Mandatory training was good and exceeded the trust target of 85% in most areas for nursing staff. Overall compliance for medical staff was 83%.
- We found that LocSSIPS had been developed for central venous access devices.
- We found good awareness of incident reporting and processes in place to sharing of learning.
- Mortality and morbidity reviews were embedded and processes within this had been developed and improved.

Is the service effective?

Requires improvement 

Our rating of effective went down. We rated it as requires improvement because:

- Whilst we found evidence of multidisciplinary care from the notes we reviewed, attendance during wards rounds was variable, and access to a microbiologist was limited.
- Whilst staff were following trust policy when using restraint, we were concerned that mental capacity was not being assessed when decisions to use restraint were made. However, information provided by the trust showed 96% of nursing and 87% of medical staff were compliant with MCA training.
- ICNARC data from April 2017 to December 2017 showed that whilst the readmission rate was in line with England average, it was higher when compared to similar units.
- We spoke with some staff who told us they had accompanied patients on external transfers without the appropriate training, however transfer training compliance was 92%.

However:

- We found care was evidence based and the process for sepsis and delirium screening was embedded. This was an improvement from the previous inspection.
- We found assessment and monitoring of pain and the nutritional and hydration status of patients was in place, we observed care plans to support this.
- The percentage of nursing staff and medical staff who had undergone appraisal was just below the trust target. A clinical educator was in post who monitored training compliance. The number of staff with a post registration certificate in critical care exceeded the 50% standard.

Is the service caring?

Good 

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

- Feedback from the patients and relatives we spoke with was positive. We observed care and interactions which were kind and compassionate and patient's privacy and dignity was maintained at all times.
- Staff recognised and responded to the emotional needs of their patients and relatives.
- The patient records we reviewed showed evidence of patient and carer involvement. This was supported by patients and the families we were able to speak with.

Critical care

Is the service responsive?

Good 

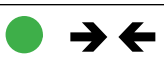
Our rating of responsive improved. We rated it as good because:

- The percentage of non-clinical transfers was in line with that of similar units; this was an improvement from the last inspection. The number of bed days with a delay of more than 8 hours was much better than that of similar units.
- Staff were able to identify and plan care to meet people's individual needs. They felt confident in providing care for patients who may require additional support, for example those with a learning difficulty or living with dementia.
- Patient diaries had been relaunched with new documents to support staff to use them. Follow up clinics were in place and appointments were offered to all levels three patients and those who had been on the unit for more than 72 hours.
- The unit received a low number of complaints.

However:

- There was no provision for relatives to make a drink on the unit and there was no overnight accommodation for relatives.
- The service did not have a critical care patient and relative support group.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- We found there was strong leadership at all levels and staff were proud to work on the unit, managers recognised the quality of care provided to patients and their families.
- Whilst still relatively new, governance processes had been strengthened with much more clinical oversight and ownership. The risk register was reflective of the risks to the service with evidence of recent review.
- There were systems in place to monitor quality and performance within the unit. Overall compliance against GPICS had improved since the last inspection; the main exception to this was medical staffing.
- The appointment of a clinical educator meant there was a renewed focus on training and education for staff.
- The vision and strategy for the unit were clearly outlined. Whilst the final decision over the plans for the unit had not been made, work was ongoing to develop the service and improve compliance with GPICS recommendations.
- Work had been done to improve engagement with families and patients. Patient diaries had been relaunched and feedback information was being collected.
- It had been recognised that provision for the Critical Care Outreach Team (CCOT) was a challenge, in response there had been changes to their shift patterns and a staffing uplift to support service delivery.

However:

Critical care

- Many of the changes and improvement made were in their infancy and needed to become embedded within the service.
- We were provided with limited examples of innovative working. We were not aware of any involvement or participation in research.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding Practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

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

The community midwives care for women with low-risk pregnancies. There are three teams of community midwives who deliver antenatal and postnatal care in women's' homes, clinics, GP practices and children's centres.

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

On the 15 June 2017, the Care Quality Commission (CQC) undertook an unannounced inspection. The purpose of this inspection was to follow up on the actions taken by the trust in relation to the Section 29A warning notice. The notice was issued in January 2017 following the previous inspection. (At that inspection we rated safe as inadequate and well-led as requires improvement, we rated effective, caring and responsive as good. The overall rating was, requires improvement).

At the follow up inspection in June 2017, which was inspected but not rated, we found:

- The World Health Organisation (WHO) surgical safety checklist was not consistently complete in any of the five records we inspected.
- Actual midwifery staffing levels were often below the planned staffing level.
- Risk registers were not displayed in clinical areas.
- The service had implemented processes to allow oversight of risks and governance. The evidence we found was not always consistent with the trust findings

During this inspection, we visited the maternity unit and spoke with ten patients and 27 members of staff. These included matrons, ward managers, midwives, health care assistants and student midwives. We observed care and treatment, looked at 10 patient records and medicines charts. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of the service.

Summary of this service

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

We rated it as good because:

- Good governance processes were in place and good systems for risk management. A risk management and patient safety strategy were in place, and the maternity services risk register was monitored and updated. Risk registers were displayed in clinical areas.
- The hospital was meeting the nationally recommended birth to midwife ratio of 1:28.
- We observed good team working, with midwives and doctors working collaboratively and with respect for each other's roles.

Maternity

- Staff told us they were encouraged to be open and honest; this had improved since the new clinical lead came into post. They also told us that the interim head of midwifery had a positive impact on the culture within maternity services at the trust.
- The service had established an 'NLaG Outstanding Midwife' award and had developed local events to celebrate midwifery staff.
- There was a Maternity Voices Partnership in place at the trust. Parents who had a child at the trust in the last three years were invited to join and share their experiences of care.
- Record keeping was of a good standard. Staff used 'fresh eyes' reviews of cardiotocography (CTG) for all women during labour, risk assessments were taking place and escalated appropriately.
- Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in obstetric theatres an adaptation of the World Health Organisation (WHO) surgical safety checklist.
- Staff were encouraged to report incidents and systems were in place following investigation for monitoring and sharing lessons learned with staff.

However:

- Medical and nursing/midwifery staff were non-compliant for mandatory training. The overall mandatory training completion rate for medical staff in maternity was 56%. Community staff, 78% and one of the inpatient wards, 70%. These were below the trust target of 85%.
- Nursing and medical staff were non- compliant with the trust targets for Mental Capacity Act and Deprivation of Liberty Safeguarding training. They were not meeting the 85% training compliance target set by the trust.
- Medical and nursing/midwifery staff were not up to date with their appraisals. They were not meeting the trust compliance target of 95%.
- Women told us they all received 1:1 care during established labour. However, from March 2017 to February 2018, data provided by the trust showed 84.8% of women received 1:1 care in labour across the trust. Following the inspection, the trust told us that these figures did not include women who delivered by caesarean section. However, the trust did not provide updated figures to include these births.
- Several policies were past their date of review and the trust was aware of this. However, each out of date policy was allocated to a member of staff to review and update; within a specific timeframe. A policy review group was also in place. We were assured by the management team that the out of date policies would be updated quickly.

Is the service safe?

Requires improvement

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

We rated safe as requires improvement because:

Maternity

- At our inspection in November/December 2016 the service was inadequate for safe, and in June 2017, when the service was inspected and not rated, we found improvements were made. At this inspection, the trust had followed their action plan to address their shortfalls and we found progress and positive improvements made. Two serious incidents were reported, and the main theme identified was bladder care. Staff were aware of this and the action taken to help prevent further concerns.
- Not all medical and nursing/midwifery staff were up to date with mandatory training. This included Mental Capacity Act and Deprivation of Liberty Safeguarding training. They were not meeting the 85% training compliance target set by the trust.
- Medical and nursing staff were not meeting the trust target of 85% for safeguarding training. For example, 59% of medical staff had completed the training and 78% of nursing and midwifery staff had completed safeguarding adults level one training.
- Women told us they received 1:1 care during in established labour. However, from March 2017 to February 2018, data showed 84.5% of women received 1:1 care in labour across the trust.
- The community midwife caseloads were non-compliant against national guidance. The level was 143 against the national guidance of 96 cases per WTE midwife.

However:

- There was a safeguarding midwife in post at this hospital. They received protected time for monitoring and managing safeguarding issues and enquiries.
- Safeguarding midwives attended child protection conferences and other external multidisciplinary safeguarding meetings.
- Procedures were in place to refer and safeguard adults and children from abuse. Staff felt confident making a safeguarding referral and received safeguarding supervision.
- Records relating to women's care were of a good standard. Risks to women were identified, monitored and managed to keep them safe. Records were kept secure in line with the data protection procedures.
- Audit data provided by the trust showed monthly resuscitation trolley checks from March 2017 to March 2018. Data showed 100% compliance at trust level, for this hospital. However, on ward 26 week commencing 15 January to 08 January 2018, the checks had been completed and not signed.
- Staff were encouraged to report incidents and systems were in place following investigation to disseminate learning to staff.

Is the service effective?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

We rated effective as good because:

- Midwifery staff both in the hospital and community reported good communication. This included information sharing between departments and cross-site working within teams.

- Community midwives were trained in postnatal 'check up's' and new-born and infant physical examination (NIPE). This would allow women to be discharged from hospital earlier, with the proviso that new-born babies would receive a NIPE check in the community within 72 hours.
- Access to a dedicated obstetric theatre team was available Monday to Friday from 9:00am until 9:00pm. Outside of these times the service utilised main theatres. There had been no incidents reported relating to the provision of theatre services.
- All women said they could access pain relief in a timely way, analgesia was offered regularly, and their pain was well managed.
- There was a specialist infant feeding coordinator. They led on the implementation and training associated with the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) standards.
- Staff we spoke with at the hospital and in the community clearly articulated the use of Gillick competency for consent of patients under the age of 16 years.

However:

- The service did not meet their appraisal target rate of 95% for medical staff, nurses and midwives. This hospital maternity service appraisal rate overall was of 84% and 80% for community staff.
- The overall appraisal completion rate was 84% for all maternity services staff; with medical staff achieving 90% compliance. Appraisal rates for qualified ward midwives ranged from 72% to 100%. Across the trust, community midwives achieved 73% compliance.
- The service provided care and treatment based on national guidance. However, several policies were past their date of review. The trust was aware of this and allocated members of staff to review and update the policies within a specific timeframe.

Is the service caring?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

We rated caring as good because:

- A review of maternity services at the site was undertaken by representatives from the trust, local Clinical Care Commissioning groups (CCG), and Healthwatch was carried out 28 September 2017. Findings stated all women spoken with had a lot of praise for the caring nature of staff in the wards, delivery suite and theatres. Staff were said to go "above and beyond" and their approach was consistently caring.
- There were guidelines and care pathways to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death.
- There was a consultant-led 'rainbow clinic'. The 'rainbow clinic' was a specialist service for women and their families in a subsequent pregnancy following loss.
- A specialist bereavement midwife was in post, who worked across sites.

Maternity

Is the service responsive?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

We rated responsive as good because:

- The service met the trust target for undertaking antenatal bookings before 13 weeks gestation (minus the agreed exclusion targets such as mothers presenting later in pregnancy). Procedures were in place to follow up women who did not attend.
- There were no maternity unit closures for the 12 months prior to inspection.
- 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.
- Midwives were available for support and guidance with special interests as part of their role. These included midwives who specialised in safeguarding, teenage pregnancy, smoking cessation, substance abuse, bereavement, and infant feeding.
- A face-to-face and telephone translation service was available, provided by 'Big Word Translation' services and British Sign Language signers.
- The trust had also applied assistive technology to their external web pages, to enable audio capabilities for those with visual impairments. The assistive technology allowed users to listen to an audio reading of web content in different languages.
- Staff were clear about the complaints process and action they should take if someone wished to complain.

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology so we could not compare our new ratings directly with previous ratings.

We rated well led as good because:

- The group clinical director had recently come into post prior to our inspection. Staff reported they were confident in this person to lead the clinical team.
- The service had a three to five-year strategy which reviewed clinical and financial pressures.
- Staff told us they were encouraged to be open and honest; this had improved since the new clinical lead came into post.
- They also told us that the interim head of midwifery had a positive impact on the culture within maternity services at the trust.

Maternity

- The service had established an 'NLaG Outstanding Midwife' award and had developed local events to celebrate midwifery staff.
- The management structure had clear lines of responsibility and accountability, and we saw evidence of frequent maternity services meetings and panels, which were appropriately attended.
- Good governance processes were in place and good systems for risk management. A risk management and patient safety strategy were in place, and the maternity services risk register was monitored and updated.
- The service used internal, cross site communication methods to inform staff of learning and changes to practice (for example, the weekly learning memorandum from the interim head of midwifery). We found highlights posted on staff notice boards and minutes of meetings where staff signed to show they were aware of the information.

However:

- The service was receiving support from NHSI in the form of an external partnership with a consultant. The aim was to support the leadership team to drive improvement. At the time of inspection support had been provided on six days and was in the early stages.
- Staff across the Women and Children's Group completed a survey in 2017, facilitated by an independent provider. Poor scores for organisational culture were noted and staff felt this was a critical situation requiring leadership changes to avoid organisational failure.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Good

Key facts and figures

Children's services at Scunthorpe General Hospital include an 18-bed inpatient ward, with two high dependency beds; a paediatric assessment unit; a 10-cot neonatal unit and four cot transitional care ward; a children's outpatient department, and a children's community nursing team.

The children's ward admitted children up to the age of 16 years or 18 years for those young people with chronic or complex conditions.

At our last inspection, we rated safe, effective, responsive and well led as requires improvement. Caring was rated as good.

During our inspection of children's services, we visited the neonatal unit; children's outpatients' clinic and Disney ward. We also looked at some other areas children and young people were seen, these areas included radiology, adult ophthalmology clinic, fracture clinic, ear, nose and throat clinic and the emergency department.

We spoke with two medical staff, 44 nursing staff including managers, five members of the multi-disciplinary team and 10 parents and three young people. We reviewed 13 children's records.

Summary of this service

Our rating of this service improved. We rated it as good because:

- We rated effective, caring, responsive and well led as good. Safe was rated as requires improvement.
- Staff had a good understanding of safeguarding and were aware of their responsibilities in relation to this.
- Patient records were completed in line with professional standards and trust policy.
- The paediatric early warning score (PEWS) tool had been improved since our last inspection and we saw appropriate assessment and escalation of children and young people.
- Staff understood their responsibility to report incidents and feedback from incidents was shared in a number of ways.
- Staff provided care and treatment in line with national guidance. The service monitored the effectiveness of care and treatment through local and national audits.
- There was effective multidisciplinary team working, both internally and externally.
- Staff understood their responsibilities when obtaining consent from young people and their parents/carers.
- Staff treated patients and their families with kindness and compassion, encouraging family members to be involved in their child's care.
- The children's services met the individual needs of children and provided a range of therapeutic interventions and specialist nurses.
- Staff we spoke with told us leaders were visible, approachable and supportive. Leaders were aware of the risks to the service and had plans in place for the management of risks.
- Effective governance processes were in place to manage risk and quality.

Services for children and young people

However:

- Medical staff were still not meeting trust targets for mandatory training and safeguarding training.
- There was no formal risk assessment tool for those patients with mental health concerns and staff had no specific training to deal with patients with mental health needs.
- Medical staffing was not compliant with national guidance.
- Some patient outcomes were worse than the national average.

Is the service safe?

Requires improvement 

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

- Medical staff were not meeting the trust target for compliance with mandatory and level three safeguarding training. This had been identified as a concern at our last inspection.
- Only 51% of nursing staff were up to date with resuscitation training.
- Nurse staffing on the paediatric assessment unit was not compliant with national guidance.
- There were no formal risk assessment tools used for those patients with mental health concerns.
- Medical staffing was not compliant with national guidance. This had been identified at our last inspection and some improvements had been made. A business case had recently been put forward for increased staffing.

However:

- We saw that appropriate safeguarding referrals were made, and staff accessed safeguarding supervision.
- A new PEWS tool had been introduced since our last inspection and we saw appropriate recording and escalation of PEWS scores.
- Nurse staffing on the ward had improved since our last inspection, with an increased number of band six nurses.
- Records were appropriately completed and stored securely.
- Incidents were reported, and staff received feedback.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance. All polices and guidance we reviewed was up to date.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. There were effective working relationships with other agencies, such as the child and adolescent mental health service (CAMHS).
- Staff attended simulation session and undertook competencies to ensure they provided effective competent care.

Services for children and young people

- Most of the staff on the neonatal unit had undertaken a post registration course and competencies to become qualified in speciality (QIS). This ensures that neonatal care is delivered by suitably qualified and trained staff.
- Staff understood their responsibilities when obtaining consent and were aware of Gillick competency.
- Transition services had improved since our last inspection.

However:

- Staff had not received any training to help them support children and young people with a mental health condition.
- Appraisal rates were worse than the trust's own target levels, despite staff telling us they had completed their appraisals. Appraisal rates varied between 24% and 100%.
- Patient outcomes in the national paediatric diabetes audit were worse than expected compared to the national aggregate for mean average HbA1c results and in the neonatal audit programme the hospital was in the bottom 25% for one measure.

Is the service caring?

Good 

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

- Staff cared for patients with compassion and respect. Feedback from patients confirmed that staff treated them with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment There was engagement through the friends and family test (FFT) which showed consistently positive results.
- Staff provided emotional support to patients to minimise their distress. Play specialists were available to alleviate anxieties.
- Information was provided to parents in a way they could understand.

Is the service responsive?

Good 

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

- The children's community nursing team and the specialist nurses promoted early discharge.
- People could access the service when they needed it. Waiting times for treatment and arrangements to admit, treat and discharge patients were in line with good practice and national guidance.
- There were clear pathways and access to support for the staff from the local child and adolescent mental health service (CAMHS).
- Facilities and premises were appropriate and child friendly with an indoor and outdoor play area.
- Adolescents were cared for in a single sex bay or nursed in cubicles to ensure separation.
- The children's service received a low number of complaints. Staff were able to tell us about shared learning from complaints.

Services for children and young people

Is the service well-led?

Good 

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

- There was good and effective local management, who were visible. Staff we spoke with talked positively about their leaders.
- Service leads understood their local challenges. Improvements had been made since our last inspection and the service leads recognised and identified their areas for further improvement.
- There was a clear and effective governance structure in place, which ensured information was fed from ward to board, and from board to ward.
- There was a supportive culture and staff we spoke with talked positively about the service.
- There was a strategy in place for the children's services. However, staff we spoke with told us they had only seen the strategy in the week prior to our inspection.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

End of life care

Requires improvement 

Key facts and figures

Scunthorpe Hospital provides 24-hour end of life services for people who live in and around the Scunthorpe area.

Between December 2016 and November 2017 there were 1,669 deaths at the trust. There is no dedicated palliative care ward but patients at end of life are nursed on wards throughout the hospital. The end of life team consists of a palliative care consultant, end of life clinical coordinator, three palliative care specialist nurses and a discharge liaison team.

We plan our inspections based on everything we know about services including whether they appear to be getting better or worse.

We inspected the hospital as part of an announced inspection between 8 and 11 May 2018. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring performance.

We reviewed two records for patients at end of life, eight records of do not attempt cardio pulmonary resuscitation (DNACPR) and thirteen electronic records of advance care plans for end of life care. We spoke with two patients and those close to them as well as observing care of two patients on the wards.

We spoke with 35 members of staff including the end of life co-ordinator, the palliative care consultant, discharge liaison team, bereavement officer, nurses of all grades, doctors, the chaplain, mortuary staff, porters and medical engineer.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- We found dirty equipment in the mortuary that meant the service did not always control infection risks.
- The service had suitable premises and equipment but did not monitor this effectively, such as the monitoring of freezer temperatures in the mortuary that required maintenance.
- Compliance with end of life mandatory training was below the trust target for nurses.
- There was only one palliative care consultant with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. The service did not manage patient safety incidents. Staff did not recognise incidents as end of life and report them appropriately.
- The service did not always monitor the effectiveness of care and treatment and use the findings to improve them. The service was not available over seven days: it was Monday to Friday only.
- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Doctors completed DNACPR documentation, but this was not consistently completed appropriately.
- Complaints were not clearly identified as end of life. This meant learning was not shared to help improve the service.
- The service did not have sufficient numbers of senior managers with the right skills and abilities to run a service providing high-quality sustainable care. There was only one palliative care consultant, there was no improvement lead or board representative.

End of life care

- The service did not have a systematic approach to continually improving the quality of its services as concerns identified following the last inspection were repeated.
- The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

However:

- The service prescribed, gave, recorded and stored anticipatory medicines well. Patients received the right medication at the right dose at the right time.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff worked together as a team to benefit patients. Specialist palliative care staff and ward staff supported each other to provide good care.
- Staff cared for patients and those close to them with compassion. Feedback from patients confirmed that staff treated them well and with kindness and provided emotional support.
- Manager across the service promoted a positive culture that supported and valued staff.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- We observed that premises were clean, however; there were two mortuary trolleys, one awaiting repair and the other in use that was visibly dirty.
- The mortuary service had suitable premises and equipment but did not monitor these effectively at night. At the time of inspection, there was a fault with the monitoring of the freezer temperature. It was monitored during the day, however; at night, it could only be monitored if on-call staff were on-site.
- The service provided mandatory training in end of life skills to staff in the trust, compliance was below the trust target of 85% for nurses. This training was not mandatory for medical staff.
- The service had only one palliative care consultant with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. This was not in line with National Commissioning Guidance for Specialist Palliative Care (2012). This had been identified at the last inspection.
- The service did not manage patient safety incidents. Staff did not recognise incidents as end of life and report them appropriately. There was no shared learning or feedback. This meant that themes or trends could not be identified to help drive improvement.

However:

- The service prescribed, gave, recorded and stored anticipatory medicines well. Patients received the right medication at the right dose at the right time.

End of life care

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

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The trust performed worse than the England average for three of the six clinical key indicators in the End of Life Care audit: Dying in Hospital 2016. At the time of the inspection not all actions on the trusts action plan were complete.
- Senior staff told us that service level agreements were in place, such as for mortuary services, however; no details were received on request from the trust.
- At the last inspection we found that the service was not available over seven days: it was only available Monday to Friday. This had not changed and was not in line with the NHS Seven Day Clinical Standards (2017) that states that specialist palliative care should be available at any time of day or night. The consultant told us that a patient would be reviewed if necessary, but this was an informal system.
- The service was not always following best practice, for example, there was currently no recommended summary plan for emergency care and treatment for patients (ReSPECT) in place. ReSPECT includes a plan for future care to guide health professionals to providing the appropriate care and treatment.
- There was currently no electronic palliative care co-ordination system (EPaCCS) in place.
- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Doctors did not consistently complete do not DNACPR documentation them in line with trust policy.

However:

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Following the inspection, the trust provided, an updated action plan which identified that all recommendations had been implemented following the End of Life Care audit: Dying in Hospital 2016.
- Staff worked together as a team to benefit patients. Doctors, nurses, porters, mortuary staff and other healthcare professionals supported each other to provide good care.

Is the service caring?

Good 

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

- Staff cared for patients with compassion. Feedback from patients we spoke with, confirmed that staff treated them well and with kindness. The service was providing bereavement questionnaires to those close to patients, however; no results were available at time of inspection.
- Staff involved patients and those close to them in decisions about their care and treatment. We observed positive, caring, respectful interactions between hospital staff and families.

End of life care

- Staff provided emotional support to patients to minimise their distress. A mental health liaison team was available if needed.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- Information provided by the trust showed between April 2017 and March 2018 37% of patients whose preferred place of death was hospital achieved this at SGH.
- The service did not always recognise complaints for the end of life service. We reviewed a complaint received prior to inspection and found this was not managed in a timely way in line with the trust policy. This meant that themes or trends could not be identified to help drive improvement.
- Patient information leaflets were available, however there were none in languages other than English or alternative formats such as Braille or easy read.

However:

- People could access the service when they needed it during weekdays. The palliative care team supported discharges to hospice care and the discharge liaison team facilitated rapid discharges to home or a care home the same day or following day.
- The service took account of patients' individual needs. Wherever possible patients were nurse in a side room, if preferred. Open visiting was available for those close to them with facilities available to be resident. Bariatric equipment was available on ward and in the mortuary.
- A system was in place for spiritual support, for a number of faiths both in wards and in the mortuary. Interpreter services were available if required as well as sign language specialists.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Leadership arrangements for end of life care at trust board level were unclear during our inspection. However, following the inspection, the trust told us that the chief nurse was the executive lead and the interim medical director was the executive lead for mortality.
- The trust had a vision for what it wanted to achieve and plans for the service that included involvement of staff, patients and community services, however; actions had been prioritised due to constraints on the service within the trust. Following the last inspection, a strategy was developed, however; the consultant told us that this was now being reviewed.
- There was only one palliative care consultant and the service did not have a service improvement lead. This was highlighted at the last inspection. There was no indication of when any additional consultant position would be recruited for the service.

End of life care

- The service did not have effective systems for identifying risks or plans to eliminate or reduce them. The consultant told us that having one consultant only in post had not been identified as a risk on the risk register. There was no system to show how the risk of the mortuary alarm sounding, during out of hours periods was being managed.
- The service did not have a systematic approach to continually improving the quality of its services and safeguarding high standards of care. The action plan following the National End of Life Care audit; Dying in Hospital (2016) was not complete and highlighted limited progress since the last inspection.
- The trusts own audit results did not always reflect what we found in patients records on inspection.
- The service accepted referrals for end of life care in the last days of life rather than the last 12 months. The service had not implemented best practices such as summary plans for ReSPECT or electronic palliative care co-ordination system.

However:

- Managers across the service, were passionate about providing good end of life care, they promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff felt supported and were proud of the services they provided.
- The service engaged well with patients, staff, the public and local organisations including the hospice to plan and manage services.
- The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Outpatients

Inadequate

Key facts and figures

Outpatients was part of the clinical support services directorate. Pathology was provided by a service managed by the trust and provided services to other trusts. A range of clinics were provided by outpatients such as surgery outpatients, medicine outpatients, ophthalmology, respiratory, diabetes, urology, neurology and ear, nose and throat.

Outpatient services were provided on all three hospital sites in dedicated outpatient areas. The majority of clinics were provided during core hours; however, a small number of evening and weekend clinics took place. Waiting lists for each speciality were held and managed by that speciality.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. The inspection was part of a comprehensive inspection. We visited Goole and District Hospital outpatients, Scunthorpe Hospital outpatients and Diana, Princess of Wales Hospital outpatients at the trust during the inspection. We inspected outpatients as part of this inspection as outpatients at the previous inspection was rated as inadequate and we found a number of concerns within the service.

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

During this inspection we visited outpatients and ophthalmology outpatients at Scunthorpe General Hospital.

Between November 2016 and October 2017 there were 169,060 outpatient appointments at Scunthorpe hospital.

We spoke with twelve patients, 22 staff and reviewed twelve patient records during our inspection

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated the service as inadequate because:

- There were 31, 295 patients overdue their follow up appointment as at March 2018. This was worse than the previous inspection.
- The trust had started to clinically validate and administratively validate some waiting lists; however, this was not complete for all patients across all waiting lists.
- Referral to treatment indicators were not met across all specialities. This had not improved since the previous inspection.
- There were 320 patients waiting over 52 weeks at the trust as at March 2018. This was worse than the previous inspection.
- The trust was performing worse than the 85% operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral.
- At our last inspection we reported medical records were not stored securely. At this inspection we found three separate areas in outpatient clinics where medical records were left uncovered, unsupervised and in open areas.

Outpatients

- From November 2016 to October 2017, the 'did not attend' rate for Scunthorpe General Hospital was higher than the England average.
- The trust did not investigate and close complaints in line with its own target.
- There was no formal strategy for outpatients at the trust and staff were not always aware of the trust vision and values.

However:

- We found nursing staff had exceeded the mandatory training completion target. Nursing staffing levels were generally as planned in outpatients. Staff had access to trust policies and audits that were relevant to outpatients were completed within specialities.
- Staff were friendly and provided compassionate care to patients and ensured privacy and dignity was maintained. Patient feedback regarding services was generally positive.
- Staff told us morale was generally good across the services.

Is the service safe?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated safe as requires improvement because:

- The previous inspection found that clinical validation and assessment of risk within waiting lists had been slow to be implemented across all specialities. The trust had started to clinically validate some waiting lists; however, this was inconsistent and not complete across waiting lists in all specialities.
- At this inspection clinical validation in terms of clinical harm reviews had been commenced but not been completed across all specialities. Clinical validation was only being completed on patients on waiting lists where they were six months overdue their appointment date, waiting more than 40 weeks for treatment or confirmed cancer patients waiting over 104 days for treatment. This did not provide assurance that there was clear oversight of the risk posed to patients on waiting lists.
- The trust declared a serious incident in May 2018 that related to a delay in a patient receiving treatment. This was found during a validation exercise.
- The clinical harm review of the patients overdue six months or more for their appointment was ongoing; however, was not yet complete at the time of our inspection. The clinical harm group had identified patients who had died whilst waiting for a follow up appointment; however there had been no formal reviews of these deaths to see whether the delay in appointments or treatment may have contributed to the patient deaths.
- The total number of patients on waiting lists had increased since the previous inspection.
- At our last inspection we reported medical records were not stored securely in outpatients. At this inspection we found three separate areas in outpatient clinics where medical records were left uncovered, unsupervised and in open areas.

However:

Outpatients

- Nursing staff met or exceeded the trusts mandatory training completion target for all mandatory and safeguarding training modules.
- All areas we visited were visibly clean and tidy. Medicines were stored securely in the areas visited.
- Nurse staffing levels were as planned in outpatients.
- Staff we spoke with were aware of reporting incidents and using the incident reporting system and were aware of the duty of candour.

Is the service effective?

Not sufficient evidence to rate

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We did not rate effective.

However:

- Staff had access to a trust intranet which contained the trust policies and procedures available to staff.
- Audit was generally carried out within the specialities that provided outpatients. A number of clinics we visited told us they completed annual audits.
- Staff in outpatients told us they were able to provide drinks to patients who had waited a long time or who required a drink.
- From November 2016 to October 2017, the follow-up to new rate for Scunthorpe General Hospital was similar to the England average.
- Staff had received annual appraisals and staff we spoke with had generally had opportunity to develop and complete further training.

Is the service caring?

Good

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated caring as good because:

- Patient feedback was mostly positive and described staff as providing compassionate care along with treating patients with dignity and respect. Staff were friendly and welcoming in clinics to patients and visitors.
- A patient questionnaire showed mostly positive results being treated with respect and dignity and regarding their overall experience of outpatients.
- Clinical nurse specialists provided additional care and support and were available in a number of outpatient clinics.
- Chaperones were available in clinics.

Outpatients

Is the service responsive?

Inadequate

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated responsive as inadequate because:

- The previous inspection found issues with referral to treatment indicators. During this inspection we found that referral to treatment indicators were not met across all specialities. There was no clear plan for recovery or a trajectory to improve referral to treatment performance.
- The previous inspection found concerns with the number of patients overdue their appointment. During this inspection we found there were 31,295 patients overdue their follow up appointment as at March 2018. This was worse than the previous inspection. During this inspection we found there were still patients without an appointment due date.
- From November 2016 to October 2017, the 'did not attend' rate for Scunthorpe General Hospital was higher than the England average.
- There were 320 patients waiting over 52 weeks for an appointment at the trust as at March 2018. There was no clear plan for recovery or a trajectory to improve the 52 week wait performance.
- The trust was performing worse than the 85% operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral. There was no clear plan for recovery or a trajectory to improve the 62-day cancer pathway performance.
- The April 2017 to April 2018 outpatient key performance indicator dashboard showed the outpatients booked slot utilisation rate was below the trust target of 95%. In April 2018 at SGH it was 81.9%.
- The service did not investigate and close complaints in line with the trust's target.

However:

- The trust was performing 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).
- Senior managers we spoke with told us they met regularly with the clinical commissioning groups regarding service delivery and attended regular business meetings for outpatients.
- Outpatient clinics had various patient information leaflets they could provide to patients and translation services were available in outpatients.
- The trust had introduced a lead for patient administration and access to address the concerns raised at the previous inspection.

Is the service well-led?

Inadequate

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Outpatients

We rated well led as inadequate because:

- Since the introduction of a patient administration and access lead for outpatients, areas such as booking appointments and staff training on referral to treatment standards had improved; however, the pace of work and increasing waiting lists remained a significant concern.
- Staff we spoke with at all levels in the trust were not always clear on the actual number of patients on waiting lists.
- Concerns and challenges around referral to treatment indicators and the number of patients overdue their follow up appointments had not been fully addressed at this inspection. The trust was working on addressing the issues; however, the overdue follow up patient backlog had increased since our last inspection. There was no clear improvement trajectory for the 31,295 patient follow up backlog.
- There had been an increase in patients waiting over 52 weeks for an appointment and no clear plan to address concerns regarding this or the 62-day operational standard for cancer patients receiving their first treatment within 62 days of an urgent GP referral.
- At the time of the inspection the trust did not have an effective performance management framework in place. Work had begun to encourage ownership of performance in the divisions.
- There was no formal strategy for outpatients at the trust.

However:

- There was a management structure for outpatients and governance systems were in place.
- Risks were documented on risk registers which were reviewed monthly.
- Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available for support when required. Morale was generally good in outpatients and staff felt supported.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Diagnostic imaging

Requires improvement

Key facts and figures

Diagnostics and radiology were part of the clinical support services directorate. There were two diagnostic imaging departments plus a medical physics department at Scunthorpe General Hospital (SGH). SGH diagnostic and radiology departments carried out CT, MRI, PET, ultrasound, fluoroscopy and a range of invasive procedures such as biopsies and injections using scans as a guide.

The department supported an external provider who carried out MRI and CT scans by providing consumables and an emergency box. The patients were all trust patients however staff and equipment were supplied by the external provider.

Radiology services were provided on all three hospital sites in dedicated diagnostic imaging suites. The departments at SGH were open seven days a week with on call services available over night to support emergency and urgent patients who needed CT and general x-rays. Patients who needed an MRI scan overnight were emergency transferred to a neighbouring trust to be scanned.

Clinical Support Services role was to provide radiography and nursing staff, administration support for receptions and all of the health records functionality. Waiting lists for each modality were managed by that modality.

During the inspection we visited the diagnostic and radiology departments, medical physics department and Pink Rose Suite.

We spoke with 25 staff across all modalities and from different disciplines and seven patients and relatives on this inspection.

Summary of this service

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated it as requires improvement at this inspection because:

- Medical staffing was low across the trust with significant vacancies and those medical staff in place were not up to date with mandatory training.
- The department did not have sufficient MRI and CT scanning equipment to meet increasing demand.
- At the time of the inspection we did not see evidence that the department was participating in local clinical audit and was therefore unable to provide evidence that policies and procedures were being adhered to. However, after the initial report was written, the trust sent us evidence to show some clinical audit was being carried out by radiologists. Patients had long waits to undergo scans, waiting lists were increasing and there was a risk of patient harm because of these long waits.
- Waiting times for urgent patient pathways were difficult to meet at SGH.
- Once treated, patients had long waits to receive the results of their tests. This was a trust wide problem compounded by low medical staffing numbers.

Diagnostic imaging

- The trust was unable to provide us with evidence of any patient engagement work in the departments such as satisfaction surveys or focus groups prior to the inspection however, after the inspection, the trust provided evidence of annual inpatient and outpatient diagnostic services satisfaction surveys. Staff did not always feel valued or have their contributions recognised by the senior management team.
- The trust wide five-year strategy for diagnostics and radiology was behind schedule and this was having an impact on the trust's ability to meet demand across all sites.
- Staff worked hard to ensure patients received the best experience possible however, equipment failures, staffing shortages and increasing demand without matching increasing capacity made this difficult to achieve.

However:

- There were processes in place to ensure patients and staff were not over exposed to radiation and sufficient staff had completed mandatory training to support patient needs.
- The department was clean and tidy.
- Patients were seen quickly on arrival and there were facilities to meet their individual needs.
- Staff had access to policies and procedures based on best practice.
- Staff were aware of their responsibilities relating to consent, mental capacity and safeguarding of vulnerable people.
- Performance against national and local standards, targets and performance indicators was closely monitored and there was a governance process that also encompassed external providers.
- Staff felt well supported locally by their manager and colleagues and the culture of the department was patient centred. The wider trust had started to engage with staff although this was a work in progress.

Is the service safe?

Requires improvement

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated safe as requires improvement because:

- There was insufficient scanning equipment in the department to meet patient demand.
- Some equipment broke down frequently. This had an impact on patient waiting times and meant appointments had to be rearranged thus impacting on waiting times.
- Medical staff who worked across the trust did not meet the target for adult safeguarding training, Prevent training and resuscitation training.
- Local rules were not up to date in every room.
- There were trust wide shortages of radiologists. This impacted on reporting rates across the trust, including SGH.
- There were radiographer staffing vacancies at SGH and locum staff were being used to cover the shortfall.
- The department had not carried out any reviews of patients who had experienced delays to check whether the delay had impacted on their diagnosis, treatment or prognosis.

Diagnostic imaging

- There had been four incidents reported where escalation of untoward findings had not taken place. There was a risk that these patients suffered harm due to delayed action and treatment.
- From January 2017 to December 2017, the trust reported no incidents classified as never events and but had one serious incident for diagnostics and radiology on the SGH site.

However:

- All areas we visited were visibly clean and tidy. We saw department staff participate in hand hygiene activities and we observed equipment being cleaned.
- Staff were aware of the risks associated with working with ionising radiation and followed safety guidance to protect themselves and their patients
- There were limited supplies of medicines used in the department however these were stored appropriately and securely.
- Equipment was maintained in line with manufacturer requirements and was in working order.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.

Is the service effective?

Not sufficient evidence to rate

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We did not rate effective. However:

- Staff in radiology told us they could provide drinks to patients who had waited a long time or who required a drink. Light snacks were also available for patients who had medical conditions.
- Patients who required pain relief as part of a procedure were able to access it.
- The departments were accessible to urgent and emergency CT scanning needs 24 hours per day and had fixed opening times for individual modalities from 7.30am until 10.30pm for some services. There was no overnight MRI scanning facility on the SGH site.
- The department had competent staff in post and a local induction for new or temporary staff working in the department.
- Patients were protected from discrimination as appointments were allocated purely based on clinical need and urgency.
- Patient outcomes were discussed, and radiographer performance was monitored and managed to ensure good quality x-rays and scans were produced. Multidisciplinary working took place with specialties to review scans and x-rays for patients with complex conditions.
- Staff had access to a trust intranet which contained the trust policies and procedures available to staff.
- The trust took part in a national benchmarking programme.
- Staff were aware of their responsibilities in relation to the Mental Capacity Act and obtaining consent from patients and had received training in supporting patients living with dementia.

Diagnostic imaging

- There was little evidence of local clinical audit carried out across the trust in relation to radiology and diagnostics.
- Although there was information in the departments about health and lifestyle choices, such as diet and, stopping smoking, health promotion was limited other than when patients requested information or when staff deemed patients to be at risk of potential harm.
- The department was not meeting the 95% target for staff appraisals. Staff we spoke with had generally had opportunity to develop and complete further training in relation to their role.

Is the service caring?

Good

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated caring as good because:

- Patients received treatment that was caring and compassionate from staff who were kind and patient.
- Patient dignity was respected.
- Staff supported patients who were anxious or needed emotional support as a result of their diagnosis. Patients could be referred for counselling if this was needed.
- Staff made sure to explain information to patients in a way that was easy for them to understand. Patients told us staff did not use medical terminology or jargon when explaining about complications and side effects.

Is the service responsive?

Requires improvement

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated responsive as requires improvement because:

- Patients had long waits to have their x-rays and scans and then further waits to have them reported thus there were delays in reports being sent to patients' GPs and potential delays to patients receiving diagnosis and treatment. The position was getting worse when we inspected.
- The department was performing worse than the England average for patients waiting more than six weeks to see a clinician. The trust was having difficulty meeting performance targets for access to CT, MRI, ultrasound and plain film x-rays for 31 and 62 day wait patients.
- Mechanical breakdown of equipment had impacted on patient access to the department and led to nearly 630 CT or MRI slots being lost.
- Information leaflets were not available in the department for patients requiring an accessible format such as easy read or braille. Of the information leaflets available seven were overdue for review.

However:

Diagnostic imaging

- There were processes in place to monitor performance against national and trust targets. These were scrutinised regularly and validated to ensure the most urgent patients were prioritised.
- Did not attend rates were low.
- There had been three compliments received for diagnostic and radiology services at SGH

Is the service well-led?

Requires improvement

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated well led as requires improvement because:

- Although senior management spoke about their visions for the departments, the trust had not kept to schedule on its five-year vision and strategy. This had a serious impact on the trust's ability to meet demand for scanning services such as CT and MRI.
- Capital expenditure for new equipment had not materialised meaning the department did not have enough equipment that was fit for purpose to meet increasing demand.
- Although the department was leasing equipment to meet additional demand, we still had concerns about scanning provision in an emergency, particularly overnight if equipment broke down.
- We had concerns that the trust had not completed a review of patients for assurance about the length of time some patients were waiting for test results.
- The trust was unable to provide us with evidence of any patient engagement work in the departments such as satisfaction surveys or focus groups.
- Some staff did not feel encouraged or supported to progress by senior leaders and felt undervalued for the additional services they provided for their patients. Some staff felt that the senior management team didn't acknowledge or appreciate the additional skills they had.
- There were problems with retaining staff that the trust was only beginning to address.

However:

- Staff at SGH told us they were well managed locally and had confidence in their line managers to address any concerns they had in a fair and timely manner.
- There were governance processes in place across the whole of clinical support services, the directorate that managed diagnostics and radiology. Staff were aware of and engaged in the process. Governance included services contracted out to other organisations.
- The trust had a risk register that was updated regularly. Specific risks for SGH were identified along with waiting list delays, delays in reporting and staffing numbers which were reported as a trust wide risks.
- There was regular data collection and information management was a key part of the management processes within the directorate. Data was used effectively to performance manage the department although capacity problems meant waiting lists were getting longer.

Diagnostic imaging

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community health services

Background to community health services

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of hospital based and community services to a population of more than 350,000 people across North and North East Lincolnshire and East Riding of Yorkshire.

We inspected all community services provided by the trust, this included community health services for adults, community end of life care and community dental services For more information, please see the background to the trust section.

Summary of community health services

Requires improvement

Our ratings went down for community health services for adults and community dental services. We rated community health services for adults and community dental services as requires improvement because:

- We had concerns that care was safe, responsive, and well led in community health services for adults.
- We had concerns that care was safe and well led in community dental services.

However:

- Our rating for community end of life care stayed the same. We rated the service as good.

Community health services for adults

Requires improvement 

Key facts and figures

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) provides a wide range of adult community and therapy services to a population of more than 350,000 people across North and North East Lincolnshire and the East Riding of Yorkshire.

Community health services for adults sits within the Division of Community and Therapy Services and was established as part of the "Fit for the Future" consultation in April 2011. It has a budget of around £27 million and has approximately 700 whole time equivalent staff.

It provides services at around 50 locations, which carry out 28 specialties for this core service. The regularity of clinics range from once a month to 56 per month at some locations.

We carried out a fully comprehensive inspection of this core service in May 2018 and inspected all five domains.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

At this inspection we visited;

- The Assisted Living Centre in Grimsby
- The Community Stroke Team (DPOW)
- The South Care Network
- The West Care Network
- The East Care Network
- The Complex Case Matrons
- The Single Point of Access Team
- The Unscheduled Care Team (otherwise known as Rapid Access Time Limited)
- The Ironstone Centre

During our inspection, we spoke with 46 members of staff, including administration staff, nurses, managers, therapists and nursing and therapy assistants. We observed staff providing care in clinics and in patients' homes. We spoke with 22 patients and relatives and looked at 12 patient records. We also reviewed performance information from, and about, the trust.

This service was previously inspected in October 2015 as part of a comprehensive inspection and was rated as requires improvement overall. We rated safe and well led as requires improvement and caring, effective and responsive as good.

In November 2016, we re-inspected the safe and well led domains and rated them as good.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

Community health services for adults

- There had been many changes in leadership at all levels throughout the division which offered little stability or continuity to teams. Staff told us they rarely saw middle or senior managers but they did feel supported by their team leaders.
- The service did not have a clear strategy for what it wanted to achieve.
- Morale was generally low in the service and there was still a feeling amongst staff that the acute hospital side of the trust did not value them. Despite this, there was a sense of pride for the care they provided to patients.
- The service had shortages in both nursing and therapy staffing which was having an impact on service delivery to patients.
- The service was not always able to respond in a timely way to meet the needs of patients, especially in the continence service, unscheduled care and therapy services.
- The service was still not consistently sharing feedback and learning from incidents. Individual staff said they rarely received feedback when they had reported an incident and we did not find any evidence of how learning was shared wider than local teams.
- Non-medical prescribers were not receiving the necessary support and supervision to ensure they were prescribing safely and in line with best practice.
- Appraisal rates for the service were not meeting the trust target of 95% and nursing staff were not receiving regular supervision to provide them with support and monitor the effectiveness of the service.
- Staff we spoke with in community and therapy services were not aware of how to identify, record, highlight and share the information and communication needs of people with a disability or sensory loss. This meant the service was not meeting the Accessible Information Standard.

However:

- We found compliance with mandatory training had improved since our last inspection. Staff we spoke with were up to date with their mandatory training and told us that they could access training easily.
- Staff had a good understanding and knowledge of safeguarding and understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.
- Staff treated patients with respect and maintained their dignity. We saw that staff had a good rapport with patients and relatives and involved them in decisions about their care and treatment.
- We saw good examples of multidisciplinary and multiagency working.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- The service did not have enough staff with the right qualifications, skills, training and experience. We found high vacancies and sickness rates in most teams, which was having an impact on service delivery to patients. For example; there were no district nurses in one of the care networks, insufficient staff in the unscheduled care team to provide a 24-hour service seven day a week and long waits for patients requiring a continence assessment and some therapy services.

- The service had not allocated a Designated Medical Practitioner (DMP) to non-medical prescribers as per trust policy. This meant they had not received regular prescribing supervision. Prescribers received a report on their prescribing from the National Prescribing Centre; however, they said this was not discussed or reviewed. This did not give us assurance that practitioners' prescribing was being monitored and they were prescribing safely and using best practice.
- The service was still not consistently sharing feedback and learning from incidents. Individual staff said they rarely received feedback when they had reported an incident and we did not find any evidence of how learning was shared wider than local teams.
- The service was not using a nationally recognised and effective risk assessment tool to assess the risk of pressure damage to patients. The tool comprised of a set of questions for nursing staff to consider when assessing whether the patient was at risk. There was no scoring system or guidance for staff on what the risk level was based on the responses to the questions, and no guidance on what action they should take to reduce any risk.

However:

- We found compliance with mandatory training had improved since our last inspection. Staff we spoke with were up to date with their mandatory training and told us that they could access training easily.
- Staff had a good knowledge and understanding of the trust's safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Compliance with safeguarding training was high for staff in community services for adults, exceeding the trust target of 85%.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Is the service effective?

Good

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

- The service provided care and treatment based on national guidance. There was a process to ensure that pathways and practice were in line with the National Institute for Health and Care Excellence (NICE) guidelines.
- Staff of different kinds worked together as a team to benefit patients. We saw good examples of multidisciplinary and multiagency working.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

However:

- Appraisal rates for the service were not meeting the trust target of 95% and nursing staff were not receiving regular supervision to provide them with support and monitor the effectiveness of the service. Some staff were not able to access the training and development they needed to acquire new skills to improve services to patients.
- Although we saw evidence of staff recording and measuring patient outcomes, the service did not have a clear approach to monitoring, auditing and benchmarking the outcomes to provide evidence of its effectiveness.

Community health services for adults

Is the service caring?

Good ➔➔

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

- Staff treated patients with respect and maintained their dignity. We saw that staff had a good rapport with patients and relatives.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment. The patient records we reviewed showed evidence of patient and carer involvement.
- Staff provided emotional support to patients to minimise their distress.

Is the service responsive?

Requires improvement ↓

Our rating of responsive went down. We rated it as requires improvement because:

- Therapy staff were not able to meet their targets to see urgent referrals within five days and routine referrals within four weeks. There were approximately 230 new patients on the waiting list for the continence service with a waiting time of six months. The unscheduled care team were not able to provide a service at night due to insufficient staffing levels and there were issues with the single point of access service meeting the response target for triage call back.
- Although the trust had developed a template to record the information and communication needs of people with a disability or sensory loss, staff we spoke with in community and therapy services were not aware of the template or of how to identify, record, highlight and share this information with others.
- The service did not meet the trust target to investigate and close complaints within 30 days. Nursing staff were not aware of any relevant complaints and action needed to make improvements.

However:

- The service planned and provided services in a way that met the needs of local people. Services were provided at multiple clinic sites across the patch to ensure they were easily accessible for patients.
- We saw examples of the service taking account of patients' individual needs. Reasonable adjustments were made for vulnerable patients attending the wound care clinic and staff in the care networks encouraged patients with a learning difficulty to participate in their own care.

Is the service well-led?

Requires improvement ↓

Our rating of well-led went down. We rated it as requires improvement because:

Community health services for adults

- There had been many changes in leadership at all levels throughout the division which offered little stability or continuity to teams. Staff told us they rarely saw middle or senior managers but they did feel supported by their team leaders.
- The service did not have a clear strategy for what it wanted to achieve.
- Staff morale was generally low across the service and there was still a feeling amongst staff that the acute hospital side of the trust did not value them. Despite this, there was a sense of pride for the care they provided to patients.
- We did not find evidence of managers engaging staff so that their views were reflected in the planning and delivery of services and in shaping the culture. The staff survey results demonstrated this and managers were aware it was something they needed to do better.
- There was limited information to measure performance and for some services within the division, there was no clear service specification. There was some evidence of internal audit to monitor quality of services but this was limited.
- The divisional risk register included the risks identified to us by staff during the inspection however; we saw that many risks had been added to the register just prior to our inspection despite the issues being long standing. This meant the actions to mitigate and manage the risk were not timely or effective.

However:

- We saw examples of positive working with external partners to provide services to the local population.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community end of life care

Good ➔➔

Key facts and figures

Community end of life care is delivered within the community by the MacMillan Specialist Nursing team, the MacMillan Healthcare team, the consultant for palliative care, the district nursing teams and the patients' respective general practitioners.

The specialist palliative care team nurses are based at two locations within the community and are part of the Community and Therapy Services of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG).

Between the dates of April 2017 and March 2018 there were 436 patients identified whose place of death was not in hospital.

Our inspection was announced and staff knew we were coming to enable us to observe routine activity.

We spoke with ten patients and five relatives. We also spoke with 34 members of staff, including senior managers, the specialist palliative care team, nurses and allied health professionals.

We observed care and treatment and looked at 16 care records of patients who were receiving either palliative or end of life care. We reviewed 10 do not attempt cardio pulmonary resuscitation forms.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The equipment and environment was visibly clean and had been serviced appropriately and marked as clean.
- Centralised store rooms for medicines and equipment were locked securely. Unused medicines were disposed of appropriately.
- Incidents were reported appropriately. There was good learning and a good proposed action plan from the one incident that we were notified of.
- There were sufficient staff to carry out a good seven-day service for community end of life care.
- The Macmillan specialist palliative care team demonstrated a good knowledge of the Gold Standard Framework and were supporting general practitioners to achieve this.
- Staff discussed and advised about nutrition and hydration with patients and their families. We observed appropriate health promotion advice given.
- Patients had anticipatory medicines in place to both treat and ease their symptoms in place should they experience them.
- Most patients, who chose to do so, were able to die in their own home.
- Staff new to the team were given a comprehensive induction package and continual support to ensure their competence. Staff had regular clinical supervision.
- There was good multi-disciplinary team work. Documentation was completed correctly.
- Staff had a good knowledge of the mental capacity act and deprivation of liberty safeguards procedures.

Community end of life care

- We observed that all staff were caring in their roles and nothing appeared too much trouble.
- Patients were able to access complementary therapies to ease their symptoms should they wish.
- Patients and their families were given sufficient information and time to both ask any questions and to have them answered satisfactorily.
- There were no complaints about the service in the year prior to our inspection and all patients and their relatives were extremely positive about the care and support they received.
- The service was well led and worked cohesively to the needs and wishes of the patients and their relatives.
- We reviewed guidelines that were in date, such as new guidelines on patients' differing spiritual and cultural needs in end of life care.

However:

- We observed that some out of date guidelines and leaflets had not been removed from the intranet and as such there was a risk that staff could access out of date guidance. We escalated this to staff during our inspection and we were told it would be dealt with immediately.
- We found one vial of out of date medicine in the medicines store.
- We found nine blood sample bottles that were out of date.
- The number of staff that had received an appraisal did not meet the trust target.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good because:

- The equipment we saw was clean and serviced appropriately and staff conducting visits had sufficient equipment to carry out their roles.
- The stores within the community hubs were locked and not accessible to unauthorised people.
- Most of the department's mandatory training figures were compliant with trust targets.
- The department used various risk assessments to assess and monitor patients initially and on an ongoing basis.
- There was sufficient trained, competent staff to provide safe care to the patients seven days per week.
- The electronic and paper-based patient records that we viewed were updated contemporaneously as soon as was practicable following the provision of care.
- Staff were aware of how to report incidents online and we observed this being carried out.

However:

- We found one vial of out of date medicine in the medicines store. There was no formal process for checking the expiry dates of medicines when we commenced our inspection, but the matron removed the out of date vial immediately and devised and implemented a daily checking list to prevent further issues.
- We found nine blood sample bottles that were out of date. These were removed immediately by staff when we highlighted this issue.

Community end of life care

Is the service effective?

Good ➔➔

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

- Care was delivered that adhered to national guidance.
- The trust prescribed anticipatory medicines to ensure that patients received appropriate medicine as soon as possible when required.
- Staff were able to discuss what they should do if there were any concerns regarding mental capacity or deprivation of liberty safeguarding.
- There was good multi-disciplinary working within the trust and with external agencies and providers.
- Staff were supported well with a comprehensive training package when they initially joined the palliative care team and were continually supported in their role by clinical supervision.
- The department monitored the care provided with audits and feedback and had robust action plans to rectify any identified learning.

However:

- The number of staff who have had an appraisal in the last 12 months did not reach the trust target.
- The service was not working towards an independent accreditation standard such as the Gold Standard Framework which was an action for development in our last inspection in 2016.

Is the service caring?

Good ➔➔

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

- Staff cared for patients and relatives with compassion.
- During our inspection we observed the palliative care team sending condolence cards to bereaved relatives. The majority of the team attended the funeral of one of the patients that they had cared for and the Macmillan healthcare team had won an award for going the extra mile and providing outstanding care to patients.
- Feedback from patients and their families was all positive about the care provided.
- We saw repeated instances where staff gave patients and their carers as much time as they needed to talk and reminisce.
- Staff involved patients and those close to them in all aspects of their care.
- Staff continued to support loved ones after the patient had died. We were told by one relative that the Macmillan team administrator had written to the universities of a patient's children to inform them of their loss to allow them time to grieve.

Community end of life care

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The department organised and provided care to meet the wishes and needs of local people.
- Patients could be referred for complementary therapies at a local hospice as an outpatient to ease their symptoms if they wished.
- Staff collected patients' medicines on their behalf and delivered to the patients' homes on occasion.
- We observed evidence of the fast track patient pathway where a patient can be transferred home to die if that is their wish.
- Patients could receive up to four visits a day and have a sitting service two nights a week to allow those caring for the patients to get some rest or time out.
- The team had a flexible approach and prioritised their activities to meet the needs of the patients.
- Staff could be contacted and provided care seven days per week, day or night.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- The service had sufficient leaders who were aware of the needs of the patients and the service.
- The service had a vision and strategy formed as part of the Northern Lincolnshire Multi-Agency End of Life Strategy Group, delivering care tailored to the people of the local area.
- Staff told us their vision for end of life care was 'our chance to get it right.'
- We observed a positive culture throughout the team.
- The department collated and managed data from service provision to evaluate and improve care provision.
- We reviewed guidelines that were in date, such as new guidelines on patients' differing spiritual and cultural needs in end of life care.

However:

- We observed that some out of date guidelines and leaflets had not been removed from the intranet and as such there was a risk that staff could access out of date guidance. We escalated this to staff during our inspection and we were told it would be dealt with immediately.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding Practice section above.

Community end of life care

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community dental services

Requires improvement 

Key facts and figures

The Community Dental Service, integrated with the trust, operates from four community venues, Scunthorpe General Hospital and Diana Princess of Wales Hospital.

The service accepts referrals from a range of partners providing active prevention; restorative treatment; periodontal and prosthetic care; minor surgery; including the extraction of teeth; treatment under sedation and general anaesthetic (GA) as appropriate; orthodontics in liaison with the surgical division; pain & anxiety management services to local needs and agreed priorities.

A service priority is the provision of oral health care to disadvantaged groups who cannot or do not use the General Dental Services (GDS): children with extensive disease, from families who do not normally use the GDS and adults and children who are disabled and /or have a compromising medical problem affecting their oral health and accessibility to dental services. The service provides domiciliary care to those who meet the criteria. The trust is the provider of treatment not generally available in the GDS.

Other key objectives of the service include Oral Health Promotion: programmes and activities are provided within the general aims set out in the Oral Health Strategy and the specific aims as expressed in the Oral Health Promotion section & epidemiological studies investigating the patterns of oral diseases in the local community. The Community Dental Service (CDS) provides both a dental public health and treatment service acting in a complementary way to the hospital and general dental practitioners to meet the needs of the population of Northern Lincolnshire.

We received feedback from four patients and spoke with 13 members of staff. We looked at dental care records for 10 people.

Our inspection between 8 and 11 May 2018 was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Some medical emergency equipment and medicines had passed their expiry date.
- Contents of medical emergency kits were not in line with nationally recognised guidance.
- Equipment was not always serviced appropriately.
- The process for manually scrubbing used instruments did not reflect nationally recognised guidance.
- The storage of re-usable dental burs did not reflect nationally recognised guidance.
- The system for ensuring emergency equipment and medicines did not pass their expiry date was not effective.
- An X-ray audit had not been completed since 2015 and the infection prevention and control audit had not identified the issues we identified during the inspection.

However:

- Staff had the qualifications, skills, training and experience to keep patients safe. Incidents were reported and acted upon. Clinical records were clear, concise and accurate.

Community dental services

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Staff of different kinds worked together as a team to benefit patients. Staff understood their roles and responsibilities under the Mental Capacity Act 2005 and with regards to Gillick competence.
- Staff cared for patients with compassion. We observed staff treating patients with dignity and respect.
- The service took account of patients' individual needs. The appointment system met patients' needs. The service dealt with complaints positively and efficiently.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a clearly defined management structure. Managers were visible and approachable. Staff engaged with patients and other dental care professionals to continuously improve the service being provided.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- We found at all locations emergency medicines and equipment required for resuscitation had passed their expiry date.
- We found at all locations the contents of the resuscitation kits were not in line with nationally recognised guidance.
- A wheelchair tipper had not been serviced appropriately.
- The procedure for manually scrubbing used dental instruments was not in line with nationally recognised guidance.
- Storage of sterilised dental burs was not in line with nationally recognised guidance.
- There was insufficient administrative staff which meant clinical staff were stretched having to perform administrative roles in addition to their clinical roles.

However:

- The service managed patient safety incidents well. Staff were familiar with the significant event reporting system. Incidents were investigated and lessons learned were shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Effective systems were in place to assess and respond to patient risk. Patients' medical histories were taken before any treatment was carried out. Staff provided patients and carers with adequate pre- and post-operative information.
- The service prescribed, gave, recorded and stored medicines well. Medicines used in the provision of conscious sedation were stored securely and appropriate records were maintained. Prescription pads were stored securely.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training included immediate life support (ILS), safeguarding children level one, two and three, safeguarding adults level one, information governance, mental capacity act and infection control.

Community dental services

Is the service effective?

Good 

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness. The dentists followed national guidelines to ensure patients received the most appropriate care.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. Audits of dental care records and conscious sedation were carried out. Results of audits were disseminated to the teams through meetings and peer review sessions.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Multidisciplinary team meetings were held for patients with complex needs and as part of best interest decision making.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Is the service caring?

Good 

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

- Staff cared for patients with compassion. Patients commented staff were friendly, helpful and polite. We observed staff treating patients with dignity and respect.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and their families or carers were fully involved and informed about different treatment options available.
- Staff provided emotional support to patients to minimise their distress. Staff took a holistic approach towards patient care. We were provided with examples of when staff provided emotional support to patients to help them relax and overcome anxieties.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people. At each location which we visited reasonable adjustments had been made to enable patients with various disabilities to access treatment.
- People could access the service when they needed it. Waiting times from treatment were generally good. Arrangements to admit, treat and discharge patients were in line with good practice.

Community dental services

- The service took account of patients' individual needs. The service was configured to reflect the needs of vulnerable people. Domiciliary visits were available for patients who could not access the clinics. Staff visited special schools, mental health units and residential homes to provide oral hygiene advice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- Effective systems and processes were not in place to ensure medical emergency medicines and equipment were checked regularly. Action to address out of date medical emergency equipment was not taken at locations we visited after identifying the issue at the first location we visited. This was because the trust did not stock the equipment required.
- Effective systems and processes were not in place to ensure equipment was serviced appropriately.
- Issues which we identified during the inspection had not been identified on the risk register or addressed by the provider.
- Quality assurance processes were not fully embedded within the culture of the service. An X-ray audit had not been completed since 2015.

However:

- The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Clinical leadership was provided by the clinical director and was supported by the dental services manager. Leaders were visible and accessible to staff.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff spoke passionately about their work and were proud to work for the service. Staff were aware of their responsibilities under the duty of candour.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The dentists engaged with other clinicians through the local dental committee and the managed clinical network. Staff worked with other health care professionals in order to improve the oral health of the region.

Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding Practice section above.

Community dental services

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Sarah Dronsfield, CQC Head of Hospital Inspection, led this inspection. An executive reviewer, Anthony Marsh, Chief Executive of West Midlands Ambulance Service NHS Foundation Trust supported our inspection of well-led for the trust overall.

The team included two inspection managers, 29 inspectors, 39 specialist advisers and three experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.