Care Quality Commission

Northern Lincolnshire and Goole NHS Trust

Diana Princess of Wales Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Accident and emergency	Good
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Inadequate
Maternity and family planning	Good
Services for children and young people	Good
End of life care	Good
Outpatients	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Diana, Princess of Wales Hospital is one of three acute hospitals forming the Northern Lincolnshire and Goole NHS Foundation Trust. The trust provides acute hospital and community services to a population of more than 350,000 people across North and North East Lincolnshire and the East Riding of Yorkshire. In total the trust has 850 beds across three hospitals and employs around 6,500 staff. Diana, Princess of Wales Hospital has 439 beds.

Diana, Princess of Wales Hospital (DPOW) provides medical, surgical, critical care, maternity, children's and young people's services for people across North East Lincolnshire. The hospital also provides accident and emergency (A&E) and outpatients' services.

We inspected Diana, Princess of Wales Hospital as part of the comprehensive inspection of Northern Lincolnshire and Goole NHS Foundation Trust, which included this hospital, Scunthorpe General Hospital (SGH) and Goole District Hospital (GDH). We inspected Diana, Princess of Wales Hospital on 24 April 2014.

We carried out this comprehensive inspection because the Northern Lincolnshire and Goole NHS Foundation Trust was placed in a high risk band 1 in CQC's intelligent monitoring system.

Overall, we rated Diana, Princess of Wales Hospital as requires improvement. We rated it good for being caring but it requires improvement in providing safe care, being effective, responsive to patients' needs and being well-led.

We rated accident and emergency, maternity, services for children and young people, end of life care and outpatients services as good. Medical and surgical services require improvement, and critical care services were rated as inadequate.

Our key findings were as follows:

- There were arrangements in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found all areas visited clean. MRSA and C. difficile rates were within an acceptable range for the size of the trust.
- There were significant vacancies with nursing and medical staff in some areas. The trust was actively recruiting into these posts. In the meantime, bank, agency and locum staff were used to fill any deficits in staff numbers. Staff could also work extra hours.
- Patients were able to access suitable nutrition and hydration including special diets. Patients reported that on the whole they were content with the quality and quantity of food provided.
- Mortality rates were improving.

Importantly, to improve quality and safety of care, the trust must:

- Ensure that there are sufficient qualified, skilled and experienced staff, particularly in A&E, medical and surgical wards. This is to include provision of staff out of hours, bank holidays and weekends.
- Review the skills and experience of staff working with children in the A&E department to meet national recommendations.
- Review the consistency of care and the level of consultant input, particularly out of hours and at weekends in the high dependency unit.
- Review care and treatment to ensure that it is keeping pace with National Institute of Health and Care Excellence guidance and best practice recommendations, particularly within the intensive therapy unit and high dependency units.
- Ensure that the intensive therapy unit uses nationally-recognised best-practice guidance in terms of consultant wards rounds and reviewing admissions to the unit.
- Review delayed discharges from intensive therapy unit in terms of the negative impact this can have on patients.
- Ensure that the designation of the specialty of some medical wards reflect the actual type of patients treated.

Summary of findings

- Ensure that there is an improvement in the number of Fractured Neck of Femur patients who have surgery within 48 hours.
- Ensure there is appropriate care planning and a paediatric early warning scoring system on the neonatal intensive care unit and that there is consistent nutritional and tissue viability screening and assessment on paediatric wards.
- Ensure that all staff attend and complete mandatory training, particularly for safeguarding children and resuscitation.
- Ensure that staff have appropriate appraisal and supervision.
- Review the effectiveness of handovers, particularly in the medical services.
- Ensure that all patient documentation is appropriately updated and maintained including documentation for mental capacity assessments and risk assessments.
- Review access to soft diets outside of meal-times.
- Ensure that reasons for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) are recorded and are in line with good practice and guidelines.
- Ensure that DNACPR orders confirm discussion with patients or family members and whether multidisciplinary teams are involved before an order is put in place.
- Review the effectiveness of handovers, particularly in the medical services.
- Ensure that all patient documentation is appropriately updated and maintained including documentation for mental capacity assessments and risk assessments.
- Ensure that reasons for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) are recorded and are in line with good practice and guidelines.
- Review the 'did not attend' and waiting times in outpatients' clinics and put in steps to address issues identified.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Good 	There were systems in place for managing incidents, risk, and learning from incidents. The department was clean with arrangements in place to manage and monitor the prevention and control of infection. There were good access arrangements for children who were treated in a designated paediatric treatment area by specialist staff. A review of staffing levels, both nursing and medical, had resulted in the need for more staff in both areas. The trust was in the process of recruiting increased numbers of nursing and consultant medical staff, although they were constrained by a national shortage of consultant applicants. We found that attendance at mandatory training was low in some areas, and there was no evidence that staff in A&E had been trained up to level 3 in children's safeguarding. There were appropriate systems in place for the management of deteriorating patients, and major incident plans for the management of emergency events and pressures. We found that staff behaved in a caring manner towards patients. We found that systems were in place to manage surges in flow and busy periods in the department. Overall, A&E was responsive. The national target, in which all patients should be assessed, treated and admitted or discharged within four hours had been met for nine out of the previous 12 months. There were appropriate facilities for children and patients with learning disabilities. We found that the A&E department was well-led by a lead consultant and a lead nurse who were aware of the problems the department faced and were engaged in finding solutions.
Medical care	Requires improvement 	We found the medical wards to be clean and well maintained. There were mechanisms in place to manage incidents and monitor some of the safety aspects of wards such as specific patient harms. There were large numbers of vacancies across the medical directorate, resulting in insufficient staff numbers to meet their establishment, or had shifts of staff without the full range of skills needed. The trust was using a significant number of temporary

Summary of findings

staff, agency and bank nurse and locum medical staff. This was an issue for all grades of staff. Mandatory training was variable across the directorate with some wards having poor attendance rate.

Clinical audits took place to ensure that staff were working to expected standards and following guidelines. The trust had highlighted that there were a number of national audits that required additional focus to ensure that they remained on schedule for completion. Nurse supervision rates varied between medical areas.

Access to diagnostic services was provided seven days a week, including bank holidays. However, patients reported there were times when they had to wait over a weekend or bank holiday to access some tests and scans. Additionally, medical input on wards was poor over bank holiday periods with some patients not being seen by a doctor until after the holiday, unless they were deteriorating.

Diana Princess of Wales Hospital offered a variety of medical speciality services. However, the designation of the specialty of some of the wards did not accurately reflect the actual type of patients treated on the wards.

There were times when patients were transferred between wards and to different sites late at night and early in the morning however the majority of patients were transferred after 7am and before 9pm.

The health needs of most patients were met and there was access to specific support services such as mental health services and therapy support.

Patients whose first language was not English were able to communicate using interpreting services and there was some patient information available in different languages.

Staff at Diana Princess of Wales hospital reported that they felt well supported by their managers and that there was an open and honest culture when things went wrong. Most were aware of the future vision of the trust and felt that the executive and senior management of the trust were accessible.

The trust had governance structures in place and took part in clinical audit and clinical effectiveness

Summary of findings

programmes to try to improve the quality of care delivered by the hospital. Patient engagement was improving and there were a number of initiatives in place to further improve engagement.
Although the division was aware of many of the risks that we identified we did not feel that these had been adequately addressed at the time of our inspection.

Surgery

Requires improvement

The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. The directorate had a large number of vacancies for both medical and nursing staff but the trust was trying to actively recruit into these vacancies. The number of staff having received mandatory training was variable across the surgical directorate. The World Health Organization safety checklist at this hospital was not fully embedded. Safety briefs prior to the start of theatre lists were inconsistent.
A clinical audit programme was in place and there was evidence of multidisciplinary working and access to seven-day services. Effective pain relief and nutritional arrangements were in place. Patients received care and treatment from competent staff, although appraisal rates for staff were variable.
The surgical services provided at this hospital were caring. Most patients we spoke with, the care we observed, and the results of patient surveys and the family and friends test, all indicated that most patients received caring and compassionate care.
The orthopeadic unit had adapted the ward environment to help meet the needs of people with dementia. The hospital could improve the number of Fractured Neck of Femur patients who had surgery within 48 hours. Most staff reported good leadership at all levels within surgery; however the risks associated with poor compliance of the WHO surgical checklist, although identified had not yet been addressed.

Critical care

Inadequate

The findings of our review of the critical care services are mixed. There were marked differences between the intensive therapy unit (ITU) and high dependency unit (HDU) and also between nursing and medical leadership. Nursing leadership and nursing care on the intensive therapy unit were to a good standard but the nursing leadership on the

Summary of findings

HDU was weak. Nursing staff on the HDU worked hard to provide suitable levels of care but the working practice arrangements did not positively support their work which negatively impacted on patient care.
There was insufficient medical leadership across the ITU and HDU the symptoms of which included the lack of pace in keeping up with nationally-recognised best-practice guidance and the fragmented medical care provided to patients on the HDU. The HDU was a particular concern, especially in terms of the care provided to non-respiratory level 2 patients. The operational policy in place for the HDU did not match the existing working arrangements and the consistency of care and level of consultant input was below par. This in turn had significant patient safety implications particularly out of hours and at weekends.
In terms of nursing care on the ITU, care and treatment followed nationally-recognised best-practice guidance and such guidance was up to date and easily accessible. In relation to medical practice, some guidance on the unit was not up to date.
Outcome data for patients on the ITU was mixed. The HDU did not collect such data which dramatically reduced the ability to assess and benchmark patient outcomes.
On both the ITU and HDU we found staff, particularly staff in direct contact with patients, to be compassionate and respectful to patients and families. We observed staff being equally caring to those patients who were ventilated and who would not have been aware of their surroundings.

Maternity and family planning

Good

There were effective arrangements in place for reporting patient/staff incidents and allegations of abuse which was in line with national guidance.
Figures showed midwifery staffing levels were below those nationally recommended. The service was aware of this shortfall in midwifery staffing and staffing and escalation protocols were followed to ensure staffing and skill mix levels were safe on each

shift. Women told us they had received continuity of care and one to one support from a midwife during labour. Medical staffing was in line with national recommendations.
Maternity used national evidence-based guidelines to determine the care and treatment they provided. There was a multidisciplinary approach to care and treatment which involved a range of providers across health care systems to enable services to respond to the needs of women. The service participated in national and local audits.
Most women spoke positively about their treatment by clinical staff and the standard of care they received. Some women felt communication and 'being listened to' could be improved. The service was well-led and understood the views of patients about their care. Concerns and best practice were shared to improve the service. Staff were encouraged to drive service improvement.

Services for children and young people

Good

Children's services generally safe. A paediatric early warning scoring system (PEWS) was used on Rainforest ward to identify a deteriorating child and there were adequate numbers of nursing and medical staff. Incidents were well reported and learned from. Children's services were effective as the hospital used evidence-based care and treatment and had a clinical audit programme in place.
Nursing, medical and other healthcare professionals were caring and children and parents were positive about their experiences. Parents felt involved in the decisions about their children's care and treatment and records were completed sensitively. The hospital were mostly meeting people's individual needs but access to information in other languages, such as leaflets for patients could be improved. The trust was improving the way it handled complaints.
Children's services were well-led. Staff were aware of the trust vision although there was no specific vision for children's services. There was a named senior registered nurse who was responsible for influencing the commissioning and management of children's services. Quality and patient experience was seen as all staff's responsibility.

End of life care

Good

There was a Specialist Palliative Care (SPC) Team located at Diana Princess of Wales Hospital. It

Summary of findings

provided support and advice to inpatient services within the hospital. Staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Overall, people were protected from abuse and avoidable harm.
There was a clear strategy for End of Life Care and the risk to achieving good end of life care was understood. Nursing staff prioritised safe high-quality compassionate care for patients at the end of life.

Outpatients

Good 

Patient outpatient areas were appropriately maintained and fit for purpose. Incidents were investigated appropriately and actions were taken following incidents to ensure that lessons were learnt and improvements shared across the departments. The infection control procedures were adhered to in the clinical areas, which appeared clean and reviewed regularly. Staffing levels were adequate to meet patient need.
Patients received appointments within 18 weeks of referral.
Patients told us staff were caring and explained their treatment to them.
The outpatient department understood the different needs of the communities it serves. The hospital monitored who used the service and the outcomes of care for the different population groups. However, the hospital had not responded to waiting times and Did Not Attend (DNA) rates. The trust planned to implement a 'go live' system in September 2014. There were no plans in place to improve the patient experience. The trust had quite high levels of cancellation of outpatient appointments.
There were clear lines of leadership within the department and staff knew to whom to escalate concerns.

Requires improvement

Diana Princess of Wales Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients

Contents

Detailed findings

Background to Diana Princess of Wales Hospital

Diana, Princess of Wales Hospital is one of three acute hospitals within Northern Lincolnshire and Goole NHS Foundation Trust. The trust was originally formed following a merger between North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospital NHS Trust in April 2001. In April 2011, the trust was established as a combined hospital and community trust and achieved Foundation Trust status on 1 May 2007.Northern Lincolnshire and Goole NHS Foundation Trust was one of 14 trusts, which were subject to a Sir Bruce Keogh (the Medical Director for NHS England) investigation in June 2013, as part of the review of high mortality figures across trusts in England. As a result the trust has been subject to enforcement action by Monitor and is currently in Special Measures.

Diana, Princess of Wales Hospital provides accident and emergency services, medical, surgical, critical care, maternity, children's and young peoples' services as well as outpatient services. The A&E department is a consultant–led, 24-hour service and 57,010 patients attended the department between April 2013 and March 2014, of these 10,622 were children. Facilities for the care of children consist of four assessment beds located within the Accident & Emergency (A&E) department.

There are nine medical wards including a medical assessment unit, an intermediate care ward and a short stay ward. The medical directorate has within it a number of different specialties including general medicine, care of the elderly, cardiology, respiratory medicine, endocrinology, gastroenterology, rheumatology and some stroke care. Stroke services have been centralised in a Hyper Acute Stroke Unit at Scunthorpe General Hospital.

Six wards provide surgical services with approximately 140 surgical inpatient beds. Surgical services include general surgery, trauma and orthopaedics, gynaecology, urology, ENT, and day surgery. In addition, there is a surgical assessment and short stay unit, and day surgery ward. There are eight theatre suites including designated emergency and trauma theatres.

Diana Princess of Wales Hospital has a seven bedded critical care unit (ITU), which includes two side rooms, with bi-directional flow (used for patients vulnerable to or who have acquired an infection); there is also a four bedded high dependency unit (HDU). The ITU comes under the critical care directorate and the HDU sits within the medicine directorate.

The maternity service provides antenatal, intrapartum and postnatal care to women. The unit delivered approximately 2,715 babies in 2012/2013.

There are 16 paediatric beds and two high dependency paediatric beds. The children's ward provided a range of paediatric services including general surgery, medicine and high dependency care. The hospital also has 12 neonatal intensive care (NICU) beds.End of life care services were provided throughout the trust. The Specialist Palliative Care (SPCT) Team is located at Diana Princess of Wales Hospital but provides support trust wide.

The outpatients' clinics saw 203,191 patients from April 2013 to March 2014.

Our inspection team

Our inspection team was led by:

Chair:
Bill Cuncliffe, Colorectal Consultant Surgeon.

Head of Hospital Inspections:
Julie Walton, Care Quality CommissionThe team of 33 included CQC inspectors and a variety of specialists:

Consultant Paediatrician, Medical consultant, ENT consultant, consultant anaesthetist, junior doctor, matron, senior nurses, nurse practitioner, physiotherapist, health visitor, student nurse and experts by experience.

Detailed findings

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, Monitor, Health Education England and Healthwatch. We carried out announced visit on 24th April 2014. During the visit we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, critical care, outpatients, maternity and accident and emergency department. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records. We held three listening events on 23rd April 2014 in Goole, Grimsby and Scunthorpe to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment we looked at as part of the inspection. The team would like to thank all those who attended the listening events.

Facts and data about Diana Princess of Wales Hospital

Trust Level Context and Facts

- The annual budget is around £300 million.
- Other locations registered for this trust are Monarch House and Community Equipment Store; these were not included in this inspection.
- There was around 105,000 inpatients and around 400,000 outpatients treated across the trust 2012-2013.

Trust Level safety

- There were 12 Never Events (events so serious they should never happen) between December 2012 to January 2014. These involved one drill guide retained in a patient's hand following surgery and a locum surgeon implanting the wrong lens in 11 patients' eyes during cataract surgery.
- There were 63 Serious Incidents between December 2012 and January 2014, wards accounted for the majority with 47.6% in total. Pressure ulcers Grade 3 accounted for 30.2% of all incidents reported, the majority of which occurred at the DPOW.

Safety Thermometer data

(It must be noted that caution should be used when comparing trust Safety Thermometer results to the national average as this does not account for trust to trust variation in the demographic make-up of the population).

- For new pressure ulcers the trust performed above the national average for the entire year.
- For new UTIs the trust performed below the national average for six months of the year.
- For falls with harm the trust performed below the national average for seven months of the year.
- The trust's infection rates for Clostridium difficile and Methicillin-Resistant Staphylococcus Aureus (MRSA) lie within a satisfactory statistically acceptable range for the size of the trust.

Detailed findings

Effective

- Tier 1 Mortality Indicators (used for the assessment of mortality). There were zero Tier 1 indicators flagged as 'risk' or 'elevated' risk for the trust.
- Other Tier 1 indicators – a risk was identified for the proportion of patients who received all secondary prevention medications for which they were eligible.
- The trust took part in all the clinical audits for which it was eligible.

Responsive

- During December 2012 and April 2013 the trust struggled to achieve the 95% target for admitting or transferring or discharging patients within four hours of their arrival in the A&E department. However, the performance did improve and in February 2014 saw the highest percentage at 98.7%.
- Cancelled operations – the trust performed similar to expected for patients not treated with 28 days of a last minute cancellation due to non-clinical reason and the proportion of patients whose operation was cancelled.
- The trust performed similar to expected with regard to patients being given enough notice when they were going to be discharged and discharge delays for more than four hours.

Well-led

- Overall sickness – 4.4%, national average is 4.2%.
- Agency spend – the trust performed better than expected for full-time equivalent bed days with 1.97 compared to a national average of 1.94.
- NHS Staff Survey 2013 – the results are organised into 28 key findings. Five of the indicators show performance that is better than the expected and placed within the top 20% of trusts nationally. Nine of the indicators were placed in the bottom 20%. Trust staff are less likely to recommend the trust as a place to work or receive treatment and report lower levels of fairness and effectiveness of incident reporting procedures and support from immediate managers.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Maternity and family planning	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and Emergency and Outpatients.

Accident and emergency

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

Information about the service

The A&E department at Diana Princess of Wales Hospital in Grimsby provides a service for people who live in Lincolnshire and North East Lincolnshire. It is a consultant-led, 24-hour service with full resuscitation facilities and designated accommodation for the reception of A&E patients.

Between April 2013 and March 2014 the A&E department saw 57,010 patients. Of this number 10,622 were children.

During our inspection, we spoke with 17 patients and relatives, and 29 members of staff. We observed care being undertaken, reviewed clinical records and tracked a patient's journey through A&E. We also inspected the environment and facilities.

Summary of findings

There were systems in place for managing incidents, risk, and learning from incidents. The department was clean with arrangements in place to manage and monitor the prevention and control of infection. There were good access arrangements for children who were treated in a designated paediatric treatment area by specialist staff. A review of staffing levels, both nursing and medical, had resulted in the need for more staff in both areas. The trust was in the process of recruiting increased numbers of nursing and consultant medical staff, although they were constrained by a national shortage of consultant applicants. We found that attendance at mandatory training was low in some areas, and there was no evidence that staff in A&E had been trained up to level 3 in children's safeguarding.

There were appropriate systems in place for the management of deteriorating patients, and major incident plans for the management of emergency events and pressures. We found that staff behaved in a caring manner towards patients. We found that systems were in place to manage surges in flow and busy periods in the department. Overall, A&E was responsive. The national target, in which all patients should be assessed, treated and admitted or discharged within four hours had been met for nine out of the previous 12 months. There were appropriate facilities for children and patients with learning disabilities. We found that

Accident and emergency

the A&E department was well-led by a lead consultant and a lead nurse who were aware of the problems the department faced and were engaged in finding solutions.

Are accident and emergency services safe?

Requires improvement

There were systems in place for managing incidents, risk, and learning from incidents. The department was clean with arrangements in place to manage and monitor the prevention and control of infection. There were good access arrangements for children who were treated in a designated paediatric treatment area by specialist staff.

A review of staffing levels, both nursing and medical, had resulted in the need for more staff in both areas. The trust was in the process of recruiting increased numbers of nursing and consultant medical staff, although they were constrained by a national shortage of consultant applicants.

We found that attendance at mandatory training was low in some areas, and there was no evidence that staff in A&E had been trained up to level 3 in children's safeguarding.

There were appropriate systems in place for the management of deteriorating patients, and major incident plans for the management of emergency events and pressures.

Incidents

- The Strategic Executive Information System (STEIS) records serious incidents and Never Events. Serious incidents are those that require an investigation. Never Events are incidents that should never occur. Notifications of patient safety incidents are classified by the degree of harm to the patient. These are no harm, low, moderate, severe, abuse and death. There were no serious incidents reported from the A&E services at this hospital from December 2012 and March 2014.
- Incidents were discussed at regular A&E governance meetings which were attended by senior A&E staff. We reviewed the minutes of a meeting held in November 2013. At this meeting there was a discussion relating to a nurse who had administered adrenaline incorrectly. Following the incident the senior nurse in A&E spoke to the nurse concerned, who was newly qualified and had not been in A&E long. The nurse was then booked on an

advanced life support course in order to help them improve their skills in drug administration in emergency situations. The minutes noted how the senior nurse supported the nurse through the investigation process.

- At this same meeting a new web-based learning system for staff was discussed. This involved access to a web page that contained anonymised information about incidents which had occurred in the department.
- Nursing staff told us that incident reporting is through the electronic 'Datix' system. Following an incident being put onto the system the senior nurse in A&E has five days to respond. Nursing staff also told us that learning from incidents was discussed at team meetings where feedback was given regarding these incidents.

Cleanliness, infection control and hygiene

- The department appeared clean and we saw staff undertaking hygiene procedures and washing their hands between patients.
- Infection control information was visible in the department.
- Infection control audits were completed every month which monitored compliance with key trust policies such as hand hygiene. Most areas within accident and emergency demonstrated full compliance from April 2013 to present.

Environment and equipment

- There was a separate entrance for people walking into the department with minor injuries and illnesses to those arriving by ambulance.
- To enter the reception area patients had to walk through the main hospital entrance and turn right for the A&E department. This prevented people walking into the department by accident or using it as a thoroughfare for the main hospital.
- Once in the reception area the doors were secured to protect against unauthorised access to the main department. However, there was an easily accessible room in the reception area for assessment and triage.
- The main department was bright and clean with the different clinical areas marked out logically.
- The resuscitation room was large with the equipment stored where it could be easily accessed in an emergency. There was also single electronic key access to drugs cupboards to prevent delays.
- Entrance from the ambulance bay was clear and wide allowing for patients to be brought into resus while other patients were being handed over to majors staff.
- Although children entered the same entrance as adults they were then taken to a children's waiting area.
- This area contained a play area and was staffed by paediatric nursing and medical staff.
- There was also a room near the resuscitation area where the families of people who were dangerously ill or had died in the department could sit.
- There was also a viewing room where people could view their loved ones who have recently died. There was a room which was used for the assessment of people with a mental health condition.
- We found that adequate equipment was available, was clean, regularly checked and ready for use.

Medicines

- Medicines were stored correctly including in locked cupboards or fridges.
- We found that controlled drugs and fridge temperatures were regularly checked.
- We observed staff checking controlled drugs in a safe and appropriate manner.
- Medications were stored in the department which could be prescribed to patients before they were discharged home.

Records

- Patient records were completed on paper and on an electronic data base.
- We observed both nursing and medical staff completing records during and after interactions with patients. These had been completed appropriately.
- We also saw staff updating the department's computer system in a timely manner. This recorded where people were in the department and when they had been discharged or transferred.
- We reviewed the minutes of a meeting of the nursing team held in February 2014. This discussed monthly records' audits undertaken in the department, and the need to complete all documentation fully.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed consent forms which were available for both adult patients, and for people with parental responsibility to consent on behalf of children. We found that these were completed appropriately.

Accident and emergency

- There were also specific consent forms for adults who were unable to give consent. The forms contained guidance on the actions to take in such cases. We spoke with the carer of a patient with a profound learning disability. They told us that when they attended A&E the staff addressed the patient and explained the proposed procedures to them in a helpful and respectful manner.
- Training for medical staff on the Mental Capacity Act 2005 was low at 29%.

Safeguarding

- Systems were in place for the reporting of safeguarding incidents so that they could be appropriately investigated by multi-agency safeguarding teams. This included designated staff having access to the child protection register, in order to check if a child was on the register and also to have any suspicions recorded on the register. As part of the process we found that local authority safeguarding authorities were contacted when appropriate.
- We found that although mandatory training in safeguarding was provided, this was poorly attended, particularly by medical staff.
- We found that 84% of nursing staff had received safeguarding adults training level 1, while 68% had received safeguarding children Level 1 and 2 training.
- Only 41% of medical staff had received safeguarding adults and children's training level 1 and 35% safeguarding children level 2.
- The information we received only showed staff being trained up to level 2. The safeguarding lead for the trust informed us that staff in A&E complete Safeguarding Adults Training at level 1 and Safeguarding Children at level 2.

Mandatory training

- We looked at the percentage of staff who had completed their mandatory training and found that for the A&E this was 63%. The trust's target for mandatory training was 95% by the end of December 2014.
- We found that 73% of nursing and support staff had completed the training. Only 34% of medical staff had completed mandatory training. We were concerned as an analysis of the data showed that some courses had very low completion figures.
- We found poor attendance/completion for medical staff on some mandatory training courses, which included Mental Capacity Act 2005 (29%), medicine awareness (38%), medical gases (6%), fire safety (29%) and resuscitation (67%).
- We were informed by the A&E managers that efforts were being made to improve performance in this area. There had been an improvement from 20% the previous year to the present 73%.
- Staff told us that the availability of mandatory training had improved.

Management of deteriorating patients

- The department used the 'national early warning system' (NEWS) protocol to identify and alert staff to a patient's condition deteriorating. This included time frames for treatment and instructions for the escalation of care. We saw that the trust planned to review the awareness and training of staff across all the hospital sites to ensure that escalation was appropriately undertaken.
- As a result of audits on vital signs and pain score the trust had plans to explore whether the electronic triage system could be improved to include vital signs and pain score, including the prompts to register and document vital signs with system administrator.
- Patients were assessed on arrival by a nurse who determined whether they could wait to be treated by an emergency nurse practitioner or a doctor in the minors area.
- If they required dressings, observations or pain relief they were triaged to ensure they were seen according to the severity of their condition.
- Appropriate patients could be treated in a primary care stream by GP's who worked in partnership with A&E staff.
- This provided a single point of entry and a seamless service for patients. There was an escalation policy, which included actions to be taken in the case of the attendance of a large number of highly dependent patients.

Nursing staffing

- Staffing levels were calculated using a recognised tool. A recent review of the staffing levels had resulted in more qualified nurses and healthcare assistants being recruited by the trust.

Accident and emergency

- We reviewed a document which showed the present nursing establishment and the increased establishment the trust were now recruiting to. This would increase the number of qualified nurses from 36.5 whole time equivalents (wte), the present establishment, to 45.2.
- The number of healthcare assistants would increase from 11.51 wte, the present establishment**,** to 16.9.
- The nurse numbers would also involve an increase in the number of emergency nurse practitioners (ENPs). ENP's are nurses who have done extended training to treat patients attending with minor conditions.
- The ENPs worked mainly with minor injuries, although they are in the process of increasing the number of those who can also treat patients attending with minor illness.
- The senior nurse for A&E told us they had recently brought in 12-hour shifts for nursing staff. They had done this after analysis they had carried out had shown that A&E departments that used the 12-hour shift system performed better than those that did not.
- Ideal and actual staffing numbers were displayed in the department for each shift.
- On the day of our inspection there were seven trained nursing staff on duty. Nurses we spoke with told us this was the normal number of staff rostered to work during the day. They also told us there were five trained nursing staff on nights.
- Rotas we reviewed confirmed these numbers while also showed that between two and three ENPs worked during the day. There were also four health care assistants on days and one health care assistant on nights.
- Nursing staff we spoke with told us that the only time there was difficulties was when the patient flow through the department to the wards was compromised. This occurred when there were no medical or surgical beds for patients to go into.
- We found that nurses were deployed to the assessment and triage of patients entering the department; and the care and treatment of patients in the minors, majors and resuscitation treatment areas. There were also team leaders in these various areas.
- We found there were two trained nurses caring for a group of six patients in the majors area. They worked in pairs so that there was always at least one of them on duty during their shift who knew the patients, for when their colleague went on their break.
- Nursing staff told us that on some occasions shifts had to be covered by temporary Bank nursing staff. This was confirmed by the rotas we reviewed.
- However, they told us that the Bank staff were all experienced A&E nurses.
- A registered sick children's nurse was available to care for children in a specialist children's assessment unit adjacent to the A&E department. This specialist children's nurse was employed by the trust's paediatrics department.
- The unit was open between 10am and 10pm, seven days a week throughout the year. After which hours children were cared for by nursing staff in the A&E department. These nursing staff were not specialist children's nurses.
- There was also a play specialist employed in the department. We spoke with this member of staff who told us part of their role is to distract children's attention when bloods are being taken or potentially painful procedures took place.
- Children with minor injuries were treated within the main A&E department while those who were medically unwell were treated in the children's assessment unit. Children who had life threatening illness or injuries were treated in the resuscitation area of A&E.
- When the children's assessment unit was open the specialist children's nurse could advise and assist staff in the A&E department.

Medical staffing

- The department had an establishment of five A&E consultants, although they presently only had four in place.
- The four A&E consultants were supported by three associate specialists, who were three senior middle grade A&E doctors.
- The lead consultant for A&E also told us they were actively trying to recruit up to their consultant establishment but were finding it difficult to attract people to the posts. They also told us they had tried to make the posts more attractive by offering them as joint appointments with the teaching hospital and regional major trauma centre at Hull. However, the lead consultant for A&E told us they had not received sufficient suitable interest in the post.
- A report from the trust's human resources directorate also showed they had an establishment of nine middle grade doctors, out of which there were four unfilled

vacancies. The report said that these posts were advertised repeatedly. It also said they were revising the job description to make the post more attractive. There was also an establishment for eight trainee doctors, all of which posts had been filled.

- The consultants worked a variable shift pattern with presence during the day on Mondays, through to Sundays. Out of hours there was always a consultant on-call. Junior medical staff told us that the on-call consultant would stay in the department during the evening until they were no longer needed.
- We spoke with an A&E registrar who told us there was always a consultant on the "shop floor" between 9am and 6pm, although they said they normally started work at 8am. They said that the on-call consultant would start at 6pm and would stay in the department until they were no longer needed. After this time they were on-call.
- They told us that at night there were two specialist registrars (experienced trainee A&E doctors) or two staff grades (middle grade doctors who are not on a training rotation), and an F2 trainee doctor (senior house officer /SHO) on duty.
- There was at least one GP working in A&E between 10am and 8pm, seven days a week throughout the year. On the day of our inspection there were three GPs working in the department. The GPs are employed by 'Core Care Links', who were commissioned by the local clinical commissioning group (CCG) to provide the service.
- The children's assessment unit adjacent to A&E was covered by a paediatric F2 trainee paediatrician (senior house officer/SHO), and a paediatric registrar, which is a senior training grade. The unit was open between 10am and 10pm, seven days a week throughout the year. Senior support was provided for the unit by a consultant paediatrician who was available within the main hospital.
- After 10pm an on-call paediatrician was available to assess and treat children in the A&E department.

Major incident awareness and training

- There was a major incident plan.
- Although this had not been practiced recently the senior nursing for A&E told us an exercise was being arranged.
- There was also a chemical, biological, radiation and nuclear (CBRN) plan, for which an exercise had recently been held.
- There was a store for the equipment used during a CBRN incident, which was tested during the exercise.
- We also found that the trust had a business continuity plan.
- There were also other specific plans including ones for adverse weather and heatwave.
- The trust had a business continuity plan dated 12 November 2013 and an overarching business continuity policy dated 25 April 2014.
- Key functions were set out in the plan in order of priority and these included bed management and site management.
- The plan outlined specific risks and a business impact analysis was included. Recovery time objectives (RTO) and maximum tolerable periods of disruption (MTPD) were not specified.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The consultants worked a variable shift pattern with presence during the day on Mondays, through to Sundays. Out of hours there was always a consultant on call. Junior medical staff told us that the on-call consultant would stay in the department during the evening until they were no longer needed. The trust was aware of this and is attempting to recruit new consultants although they were limited by the numbers of trainees wanting to become A&E consultants.

Although staff appraisal rates were low at 63.80% this was an improvement on earlier performance.

There was evidence of multidisciplinary working and the provision of a seven day service.

Evidence-based care and treatment

- We found there was a database on the A&E computer system which contained treatment protocols for various conditions.
- We found that clinical governance meetings held on a monthly basis discussed new NICE (National Institute for Health and Care Excellence) guidance and updates to guidance.

Accident and emergency

- We reviewed treatment protocols and flow charts for the treatment of various conditions. We observed staff appropriately following these procedures.
- A 'national early warning system' (NEWS) protocol was used in the treatment of patients. This included time frames for treatment and instructions for the escalation of care. NEWS is a system developed by the medical and nursing royal colleges.
- We found that the ENPs had protocols for the treatment of patients with minor injuries. There were also patient group directions (PGDs) which allowed them to administer medicines.
- The A&E department participated in all the clinical audits it was eligible for and the trust had taken action make improvements where shortfalls had been identified. For example, a patient information leaflet 'A Guide to Seizures' had been developed in order to provide information and advice for patients who suffered from seizures. Stroke consultants had been asked to educate all members of the clinical team regarding the need for an initial assessment within 72 hours following a patient presenting with stroke symptoms as a result of the Sentinel Stroke National Audit Programme.

Pain relief

- We found there were procedures in place and that assessment and triage nurses checked on patients in the waiting room to ensure they did not require pain relief.
- We also observed nurses in the majors' area giving pain relief to patients and patients confirmed that they were provided with pain relief.
- The College of Emergency Medicine (CEM) 'Pain in Children' audit was undertaken in 2011. This showed that 33% of children in severe pain received analgesia (pain relief medication) within 20 minutes of attendance in A&E. This was against a CEM standard of 50%. The figures also showed that 83% of children received analgesia within 30 minutes, while 100% received it within 60 minutes. These latter two results exceeded the CEM standard.
- This was the last CEM audit undertaken in this area and no further discussion of this subject was noted in audit meeting minutes from December 2013.

Nutrition and hydration

- We observed patients being offered drinks by staff where there clinical condition allowed them to take fluids.
- We reviewed minutes of a meeting of the nursing team, held in February 2014, which reminded staff to fill in fluid balance charts, especially in the case of patients who we being admitted to the wards.

Patient outcomes

- We found that the department took part in audits organised by the College of Emergency Medicine, including into pain relief in children, and feverish children.
- Audits undertaken in the department were discussed on a monthly basis at audit meetings attended by medical and senior nursing staff.
- The meeting held in March 2014 discussed audits which were being undertaken into severe sepsis and septic shock, paracetamol overdose, and moderate and severe asthma.
- The A&E services trust-wide performed worse than the national average for un-planned re-admittance.

Competent staff

- Nursing staff told us they had regular appraisal. They felt they were given appropriate support and supervision from their clinical managers.
- Junior A&E doctors had regular supervision from the A&E consultants. They felt that the atmosphere in the department was supportive.
- The trust records for the appraisal of all staff in the trust's medical directorate, which included A&E at Grimsby, was 63.8% for February 2014. This showed a continued improvement from July 2013, where compliance was at 46% for the medical directorate at Grimsby. Until February 2014 the locations were counted separately.
- Revalidation for emergency medicine consultants throughout the trust was at 57.1% as of November 2013. This was against an expected completion rate of 64%. This was the latest data which was available from the trust.

Multidisciplinary working

- There was multidisciplinary working with GPs, with patients being assessed on arrival as to whether they should be seen in one of the two GP consulting rooms.

Accident and emergency

- We spoke with an A&E registrar who told us that there was full access to radiology services during the day. Between 5pm and 11pm there was a radiologist on call, while after 11pm there was an independent organisation which provided a reporting service on x-rays and scans.
- There was a team, including physiotherapists and occupational therapists to assist with the discharge of patients from the department.
- We case tracked a patient form their admission to A&E through their handover to the Rapid Response Nurse, and their discharge from the department. Patients are transferred to the rapid response team, which is not managed by the trust, when they do not need admitting to the hospital but are not well enough to go home. The rapid response nurse obtains an emergency community bed and avoids unnecessary hospital admission.
- We found that the local mental health trust provided a crisis team, which assessed people who attended with mental health issues. This team was contacted by staff in the department when required.
- The department was not a place of safety, under the terms of the Mental Health Act 1983. However, there was a designated room where mental health professionals could assess patients.
- We found systems in place for the referral of people who needed help with problems they might have with the abuse of drink or drugs.

Seven-day services

- A&E is a 24-hour, seven-day-a-week service.
- The consultants worked a variable shift pattern with presence during the day on Mondays, through to Sundays. Out of hours there was always a consultant on call. Junior medical staff told us that the on-call consultant would stay in the department during the evening until they were no longer needed.
- We spoke with an A&E registrar who told us there was always a consultant on the "shop floor" between 9am and 6pm, although they said they normally started work at 8am. They said that the on-call consultant would start at 6pm and would stay in the department until they were no longer needed. After this time they were on call.
- They told us that at night there were two specialist registrars (experienced trainee A&E doctors) or two Staff Grades (middle grade doctors who are not on a training rotation), and an F2 trainee doctor (senior house officer/ SHO) on duty.
- They said that at weekends there were usually less doctors although the department was busier. However, they did not feel this was unsafe.
- There was at least one GP working in A&E between 10am and 8pm, seven days a week throughout the year.
- At night there were five trained nursing staff working in the department.
- The children's assessment unit adjacent to A&E was covered by a paediatric F2 trainee paediatrician (senior house officer / SHO), and a paediatric registrar, which is a senior training grade. The unit was open between 10am and 10pm seven days a week throughout the year. Senior support was provided for the unit by a consultant paediatrician who was available within the main hospital.
- After 10pm an on-call paediatrician was available to assess and treat children in the A&E department.
- A registered sick children's nurse was available to care for children in a specialist children's assessment unit adjacent to the A&E department. This specialist children's nurse was employed by the trust's paediatrics department.
- After 10pm children were cared for by nursing staff in the A&E department. These nursing staff were not specialist children's nurses.
- Imaging services were available out of hours. Between 5pm and 11pm there was a radiologist on call, while after 11pm there was an independent organisation which provided a reporting service on x-rays and scans.
- The mental health crisis team was available on a 24-hour basis.
- Pharmacy services were available on a 24-hour basis, with an on-call pharmacy for out of hours.

Are accident and emergency services caring?

Good

We found that staff behaved in a caring manner towards patients. Nursing and medical staff fully involved patients in their care.

Accident and emergency

Compassionate care

- Completion of the friends and family test by patients was low within the department, although the percentage completion rate has increased from 1% to 6%.
- We found the friends and family test forms were readily available in all parts of the department.
- During our inspection we observed that staff behaved towards patients in a caring and compassionate manner.
- The results of the CQC Adult Inpatient Survey 2013 found the A&E departments performing about the same as other trusts for care and treatment.

Patient understanding and involvement

- We observed both nursing and medical staff fully involving patients in their care.
- Patients told us that staff fully explained to them their diagnoses and treatment options.

Emotional support

- While in the department we did not witness emotional support being provided to patients or their relatives.
- There was a room for the families of people whose loved ones had recently died, or had been brought in dangerously ill, where they could talk with staff in private. In this room information leaflets were available although stored in a cupboard so as not to upset people unnecessarily.
- We reviewed a leaflet which gave information about the multi-faith chaplaincy service available in the trust, including for people whose relatives had died in A&E. This included an out-of-hours service.

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

Good

Overall, A&E was responsive. The national target, in which all patients should be assessed, treated and admitted or discharged within four hours had been met for nine out of the previous 12 months. There were appropriate facilities for children and patients with learning disabilities.

Service planning and delivery to meet the needs of local people

- There was an escalation policy for when the department was busy and an operations centre where surges in demand were managed. This was done through organising the discharge of patients in the hospital and obtaining greater levels of support from within the trust as a whole and from partner agencies.
- There were also major incident plans for the management of demand in exceptional circumstances.

Access and flow

- Over the year April 2013 to March 2014 95.3% of patients were treated within four hours, although this was not the case for three out of the 12 months. The standard is that 95% of patients should be treated within four hours. The percentage of A&E attendances less than four hours from arrival to admission saw a high of 98.7% in February 2014.
- The department also breached the standard that ambulance patients had to be handed over to A&E staff within 15 minutes. The trust informed us following inspection that the information on handover had yet to be validated. Information from board meetings regarding key performance indicators showed that the level of breaches for this standard was around 11%.
- However, actions to improve on ambulance handover times were undertaken in cooperation with the ambulance service.
- When there were delays in ambulance handover times, and generally when the department was full, staff opened four escalation cubicles which were positioned next to the ambulance entrance, opposite the resuscitation area.
- There were also escalation processes which put ambulances on divert. This involved patients being conveyed to other local A&E departments in Scunthorpe and Hull.
- We spoke with two ambulance paramedics who told us that the handover times had improved and that patients now did not have to wait as long as they did previously.

Meeting people's individual needs

- There was a children's assessment unit adjacent to the A&E department. It was staffed by a registered sick children's nurse and two paediatric doctors. It contained a children's play area which contained various toys. The atmosphere was relaxed and conducive to the care of children.

Accident and emergency

- There was also a play specialist who told us how they were used in the children's area and the main A&E department to help distract children's attention when they were having cannulas placed in their veins, or were undergoing uncomfortable procedures.
- There were systems in place for the provision of translation services for people whose first language was not English.
- We found that although there were systems in place for the provision of interpretation services for people who communicated using British Sign Language (BSL) staff were not fully aware of these. The senior nurse for A&E had sent nursing staff on a training course where they had learned how to communicate and fully assess the holistic needs of people with a learning disability, and/or a mental health condition.
- We spoke with carer of a patient with a learning disability who had been treated in A&E. They told us the patient was treated with respect and dignity in the way staff communicated with them.

Learning from complaints and concerns

- We reviewed the minutes of A&E governance meetings where issues raised as complaints or concerns were discussed.
- Nursing staff told us that learning from complaints were discussed at staff meetings.
- However, the minutes of nursing staff meetings we reviewed did not contain a discussion of complaints issues.

Are accident and emergency services well-led?

Good

We found that the A&E department was well-led by a lead consultant and a lead nurse who were aware of the problems the department faced and were engaged in finding solutions.

Changes recently made in the management of the department had led to a rise in morale which had contributed to a working atmosphere beneficial to patients.

Vision and strategy for this service

- The lead consultant for A&E services in the trust told us that work was taking place on developing a vision and strategy for the service. This included a closer working relationship with the A&E department in Scunthorpe and the minor injuries unit at Goole.

Governance, risk management and quality measurement

- As an organisation the trust had systems in place for governance, the management of risk and the measurement of quality, which were applied in the A&E department.
- These included monthly meetings to discuss clinical governance issues which were attended by A&E consultants, senior nursing staff and managers. We found these meetings fed into trust level quality assurance meetings, and down to staff meetings held in the A&E department.

Leadership of service

- At the time of the inspection the A&E department at Grimsby was managed clinically by a lead consultant and a lead nurse, who reported into the directorate of medicine, which was managed by a clinical director, a general manager and a senior nurse.
- We spoke with the recently appointed lead nurse for the A&E department, who explained to us the changes they had made in the way nursing staff were recruited to the department, including bringing a practical element into the interview process. He felt this ensured nurses came to the department with the right skill set.
- The department was considering introducing an alternative to the existing shift pattern. Two new shift pattern models were being worked up for review at the nursing establishment review, one of which included a twelve hour shift.
- We spoke with members of the nursing staff who felt that he provided good leadership for the department and helped raise morale.
- The recently appointed lead consultant who was also responsible for the A&E at Scunthorpe and the minor injuries unit at Goole explained how he had brought systems into place in order to review the work and decision making of the A&E medical staff. He felt this improved their performance and helped them learn from any mistakes.
- He also explained how they used audit and general staff meetings as a way of continually improving the service.

Accident and emergency

- We spoke with trainee medical staff in the department who felt that they were given support and encouragement.
- We found that both the nursing and medical leaders worked with the nursing and medical leadership of the medical directorate. This allowed the views and needs of the department to be placed within the strategy of the directorate as a whole.
- The directorate was responsible to the trust's executive leadership.

Culture within the service

- Nursing staff told us that morale in the department had improved and that they felt listened to.
- Junior medical staff told us that that the senior doctors were approachable and helpful.

Public and staff engagement

- Nursing and medical staff told us they felt listened to and there were processes within the department and the trust to gain the views of staff.
- However, we did not see any evidence outside of the friends and family test of the A&E department engaging with the general public.

Innovation, improvement and sustainability

- There were systems within the trust which encouraged innovation.
- Both medical and nursing staff told us that the new senior nurse for A&E had brought in new ways of working and a new approach which had improved the morale of the nursing workforce.
- We spoke with the new senior nurse for A&E who told us that they had sent staff on a specialist training course in communicating with people who had a learning disability and/or a mental health condition.
- Following discussion with staff they were considering changing the working pattern of nursing staff by introducing a different shift pattern.
- They also told us they had introduced a practical element to interviews for new nursing staff where candidates were asked to take part in clinical scenarios. These included cannulation of "dummy IV arms".
- In addition to this they had introduced live trauma exercises where a practice trauma call was put out and nursing and other staff were assessed as to their performance.

Medical care (including older people's care)

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

Information about the service

Diana Princess of Wales hospital at Grimsby has nine medical wards, including a medical assessment unit, intermediate care ward, and a short stay ward. The medical directorate has within it a number of different specialties including general medicine, care of the elderly, cardiology, respiratory medicine, endocrinology, gastroenterology, rheumatology and stroke care.

We looked at the records of 16 patients, spoke with 16 patients and relatives, spoke with 10 doctors, seven nurses, five therapists and four ward managers. We visited five wards and carried out observations on the wards we visited. Before the inspection, we reviewed performance information from and about the trust.

Summary of findings

We found the medical wards to be clean and well maintained. There were mechanisms in place to manage incidents and monitor some of the safety aspects of wards such as specific patient harms. There were large numbers of vacancies across the medical directorate, resulting in insufficient staff numbers to meet their establishment, or had shifts of staff without the full range of skills needed. The trust was using a significant number of temporary staff, agency and bank nurse and locum medical staff. This was an issue for all grades of staff. Mandatory training was variable across the directorate with some wards having poor attendance rate.

Clinical audits took place to ensure that staff were working to expected standards and following guidelines. The trust had highlighted that there were a number of national audits that required additional focus to ensure that they remained on schedule for completion.

Access to diagnostic services was provided seven days a week, including bank holidays. However, patients reported there were times when they had to wait over a weekend or bank holiday to access some tests and scans. Additionally, medical input on wards was sometimes poor over bank holiday periods with some patients not being seen by a doctor until after the holiday, unless they were deteriorating.

Medical care (including older people's care)

Diana Princess of Wales Hospital offered a variety of medical speciality services; however, the designation of the specialty of some of the wards did not accurately reflect the actual type of patients treated on the wards.

There were times when patients were transferred between wards and to different sites late at night and early in the morning however the majority of patients were transferred after 7am and before 9pm.

The health needs of most patients were met and there was access to specific support services such as mental health services and therapy support. Patients whose first language was not English were able to communicate using interpreting services and there was some patient information available in different languages.

Staff at Diana Princess of Wales hospital reported that they felt well supported by their managers and that there was an open and honest culture when things went wrong. Most were aware of the future vision of the trust and felt that the executive and senior management of the trust were accessible.

The trust had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital. Patient engagement was improving and there were a number of initiatives in place to further improve engagement.

Although the division was aware of many of the risks that we identified we did not feel that these had been adequately addressed at the time of our inspection.

Are medical care services safe?

Requires improvement

There were mechanisms in place to manage incidents and monitor some of the safety aspects of wards such as specific patient harms. This was done using nationally recognised tools. On the whole, wards were clean. However, there were instances when wards were untidy, crowded with equipment and sometimes unclean. There was sufficient equipment on most wards to meet people's moving and handling needs although sometimes wards had to borrow equipment such as hoists from each other.

Record keeping on the medical wards varied in standard. Some were completed well and reflected patient's needs, wishes and interactions however some were not completed fully and documents such as DNACPR were not always filled in fully, with information about rationale behind decisions or information about patient and family discussions. There was some evidence that staff were aware of the Mental Capacity Act 2005 and its application. However, this was not always supported by the appropriate documentation.

Due to the large number of vacancies across the medical directorate, there were times when wards had problems with insufficient staff numbers to meet their establishment, or had shifts of staff without the full range of skills needed. The trust was using a significant number of temporary staff, agency and bank nurse and locum medical staff. This was an issue for all grades of staff.

Mandatory training was variable across the directorate with some wards having poor attendance rates. This meant that staff were not always up to date with current guidance, practice and procedures.

Incidents

- There had been 30 serious incidents reported trust wide for medical areas between December 2012 and March 2014, 15 of these were reported for this hospital. Pressure ulcer Grade 3 accounted for most of the incidents reported.

Medical care (including older people's care)

- There were systems in place to report incidents. Incidents were reported via an electronic Datix system. Staff were all able to access the system. Lessons learned were discussed with and fed back to staff by the ward manager.
- Due to the trust's previously high mortality rates in some specialties, the trust had regular mortality and morbidity meetings. In recent months, the standardised hospital mortality indicator (SHMI) has improved.

Safety thermometer

- The trust had signed up to the NHS North of England Transparency Project, which meant that from November 2013 the trust would be publishing data on the degree of harm experienced by patients including pressure ulcers, falls, staffing levels and performance on the patient experience (Friends and Family Test).
- Safety thermometer information was clearly displayed at the entrance to each ward. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections and new pressure ulcers. The trust was performing slightly worse for pressure sores, particularly in the over 70s. Pressure ulcer Grade 3 accounted for 30.2% of all incidents reported, the majority 52.3% occurred at the DPOW.
- The trust was performing better than the national average for falls and catheter acquired infections.
- Risk assessments for falls were taking place on patients and there was work being undertaken by the trust to try to reduce the incidence of avoidable falls.

Cleanliness, infection control and hygiene

- Generally we saw the wards were clean. Some of the wards, however, had corridors that were cluttered with equipment and medical record trolleys.
- There were policies and procedures in place to ensure that any patients carrying an infection were managed appropriately, including barrier nursing procedures where applicable. We saw that some patients on the wards were being barrier nursed.
- All of the wards displayed information about how long they had been infection free. These timescales varied from 200 days to over one year.
- There was personal protective equipment (PPE) and alcohol hand gels on display in the wards and at the entrance to each bay. Staff were observed using the PPE and hand gels when then entered and left people's bays and before and after delivering treatment and care.
- Staff were regularly audited to make sure that they were following the correct hand hygiene techniques. Any staff identified as not using the correct techniques were given information about where their technique was lacking and retested.
- From 1 April 2013 to 31 March 2014, the trust performed within expectations for rates of C.difficile infection.

Environment and equipment

- When we carried out observations on the ward, we found that generally there was enough equipment to safely meet people's needs. For example, there were sufficient hoists and slings, stand and turn aids and walking frames to make sure that people were supported to move in the most appropriate and safe way. Occasionally staff had to borrow equipment such as hoists from other wards, but this was infrequent.
- There was resuscitation equipment available and accessible on the ward.
- The resuscitation equipment had been checked regularly to make sure it was in good working order and that emergency drugs stored on it were within date.
- When the Medical Deanery visited the trust in March 2014, they found that the trusts IT system did not readily identify where patients who were medical outliers (patients cared for on a ward other than the speciality they were admitted to) were. A handwritten white board in the medical admissions unit listed the whereabouts of patients and nursing staff could have difficulty locating the appropriate medical team for the patient.

Medicines

- Medication was stored securely.
- There was a doctor routinely present on the ward most days other than bank holidays when the wards were covered by the on-call rota. Staff were able to access medication as needed.
- Medication needed out of hours was accessed via the doctors on call.
- Medication records showed that on the whole drugs were given to patients in accordance with instructions and charts were signed appropriately.

Records

- The standard of record keeping on the wards varied. We reviewed 16 care records, 12 demonstrated that risk assessments had been carried out. However, four others had gaps and were not always competed fully.

Medical care (including older people's care)

- Discussions with patients and their relatives were not always documented. It was not always clear what treatment and care patients had received such as whether action had been taken when people were at risk of malnutrition or pressure sores.
- The trust had carried out clinical audits of records, identified some areas for improvement and was working with staff to implement improvements.
- Some records were in electronic format accessible via a computer. All disciplines of staff were able to access and contribute to these records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was documentary evidence that patients were consented for treatments appropriately. We observed staff asking people for verbal consent prior to assisting them.
- Staff attendance at training about the Mental Capacity Act 2005 varied from ward to ward, with some having 100% attendance and others having only 40% attendance.
- From our discussions, we found that staff understood the Mental Capacity Act 2005 and were able to identify when it should be used and apply it appropriately.

Safeguarding

- The trust had a safeguarding lead.
- Staff were aware that there was a safeguarding policy and the action they should take if they had any safeguarding concerns
- Staff attendance at vulnerable adults level 1 and children level1 safeguarding training varied from ward to ward in the medical division. The majority of wards had met the Trust standard rate of 75% attendance. However, attendance from some wards was as low as 58%.

Mandatory training

- Information provided to us by the trust showed that overall, mandatory training was at 71% complete for the medicine directorate.
- The rate of attendance for various specialties within the medical directorate varied between 36% and 92%.
- Only 67% of staff on elderly care wards were up to date with their moving and handling training and 61% up to date with their slips trips and falls training. This meant that patients were not always supported by staff who knew how to do so safely.
- Trust data showed that approximately 72% of staff had received resuscitation training; however this varied greatly between medical areas.

Management of deteriorating patients

- Diana Princess of Wales hospital used a system called Web V to manage and monitor patients. The system was used in conjunction with the National Early Warning Score (NEWS) and allowed staff to monitor whether patients were receiving timely repeat observations and whether their condition was improving, stable or deteriorating.
- The trust had introduced hourly roundings on all but one ward. This meant that staff routinely checked on each patient at least every hour. This meant that staff could assist people and also identify any changes in people's conditions.
- When patients were identified as deteriorating, staff told us they were aware of action to take. They told us that they were able to access medical support 24 hours per day either from medical staff on the ward, or from doctors on call. They said there were never any problems accessing support if patients were deteriorating.

Nursing staffing

- Staffing levels for wards were calculated using the safer care tool. Work had recently been undertaken by the trust to reassess the staffing levels on wards and increase them. This was to ensure that staffing establishments reflected the acuity (needs and dependency) of patients.
- The staffing establishment and actual staffing levels were displayed on a notice board in the corridor. On the day we inspected the wards, actual staffing levels were the same as the establishment staffing levels although this was not always the case on most wards.
- There had been problems with long term sickness on most of the wards we visited. Bank and agency nurses were used to make sure that staffing levels were safe. To ensure continuity of care regular bank and agency staff who were familiar with the wards were used whenever possible.
- One ward had 5 wte vacancies. In November 2013, over the month, one ward was 7.32 wte staff short another was 5.33 wte staff short. In January 2014 one ward was 4.35 wte staff short, another was 3.34 wte short and a third was 2.77 wte short.

Medical care (including older people's care)

- In January 2014 one ward had 422.68 unfilled duty hours, another had 236.33 and a third had 149.83. Only one ward in the directorate had more than their established staffing level over the month.
- The trust was in the process of a large recruitment drive and had already employed over 100 new nurses to fill vacancies. Recruitment was ongoing.
- Ward managers told us that although they were meeting their staffing establishments more often than not, sometimes they had problems with the skill mix of staff who couldn't always perform all of the tasks required of them such as taking blood and inserting cannulas.
- We observed on nursing handover. Staff discussed each patient's changing needs and any changes in their treatment or health.

Medical staffing

- There was a significant number of medical staff vacancies at all grades, including middle and consultant level. The trust was using a large number of locum medical staff to cover vacancies.
- In February 2014, 4.55 wte locum junior doctors were employed and 4.15 wte consultant locums were used to cover vacancies and gaps across the medical services at DPOW.
- Junior doctors told us there was a need for an increase in the number of junior doctors available out of hours and at weekends. They told us that they were concerned about their workload at night because sometimes they were very busy and struggled to deal with all of the demands on their time thus increasing the risk of harm to patients.
- Junior doctors told us that senior medical staff were contactable by phone if they needed any support.
- We attended one morning medical staff handover meeting. We found that the meeting was well attended, effective and informative.

Major incident awareness and training

- The trust employed a resilience manager and had plans in place to manage unexpected or unprecedented events which would enable services to continue to be delivered.
- The trust had a business continuity plan dated 12 November 2013 and an overarching business continuity policy dated 25 April 2014.
- Key functions were set out in the plan in order of priority and these included bed management and site management.
- The plan outlined specific risks and a business impact analysis was included. Recovery time objectives (RTO) and maximum tolerable periods of disruption (MTPD) were not specified.
- There were arrangements in place to deal with winter pressures such as an escalation process when there were extreme pressures on beds such as opening extra beds on some wards and bringing extra staff to help deal with increased demand.

Are medical care services effective?

Requires improvement

Staff worked in line with National Institute for Health and Care Excellence (NICE) guidelines.

Access to diagnostic services was provided seven days a week, including bank holidays. However, patients reported there were times when they had to wait over a weekend or bank holiday to access some tests and scans. Additionally, medical input on wards was poor over bank holiday periods with some patients not being seen by a doctor until after the holiday, unless they were deteriorating.

Clinical audits took place to ensure that staff were working to expected standards and following guidelines. The trust had highlighted that a number of national audits required additional focus to ensure that they remained on schedule for completion. Nurse supervision rates varied between medical areas.

There was evidence of good multidisciplinary working on wards and on the whole patients were happy with their access to pain relief.

Evidence-based care and treatment

- Staff worked in line with National Institute for Health and Care Excellence (NICE) guidelines. However, the trust was only assured of 70% compliance at the time of the publication of the Quality Accounts 2013/14, this was across all directorates. The aim was to be 90% compliant by March 2014. The Governance and Assurance Committee received updates quarterly and information in February 2014 showed that the 90% had not been achieved.
- The quality accounts also reported that the compliance with assessing trust technology approved guidelines

was at 85.5%, which was risk rated red at the time of the report. Lead clinicians had not always been assigned and gap analysis not consistently completed or returned to administrators.

- Ward managers held ward staff meetings and produced newsletters to make sure that all staff working on wards were aware of any changes to working practice or equipment used. We saw minutes of governance meetings that demonstrated that when new guidelines were received a lead was identified who would undertake a gap analysis for their service so any changes to practice could be enacted.

Pain relief

- Patients were able to request pain relief and there were systems in place to make sure that additional pain relief could be accessed via medical staff if required.
- Patients we spoke with had no concerns about how their pain was controlled.
- Pain assessments were carried out with some patients, but this was not recorded consistently across the medical directorate.
- As a result of participating in the National Pain Audit 2013/14 the trust had identified the need to improve the quality of advice given to patients on managing pain, particularly following consultation.

Nutrition and hydration

- Patients were able to access suitable nutrition and hydration including special diets during meal times and when these had been pre-planned. However, it was not always possible to access things like soft diets outside of meal times.
- Patients reported that on the whole they were content with the quality and quantity of nutrition
- We observed that there were jugs of water on patient's side tables and these were changed regularly throughout the day. Three fluid balance charts were reviewed, one out of three was fully completed.
- Following the Sir Bruce Keogh Review the trust had implemented a hydrant project and introduced the MUST screening tool (Malnutrition Universal Screening Tool) to better identify patients at risk of malnutrition and dehydration.
- The trust had also began rolling out volunteers at mealtimes to assist feeding of dependant patients, alongside a generic snack list for ward areas for patients at risk of malnutrition.
- We were informed of a trial of a new role of dysphagia assistant for patients with known swallowing problems to ensure feeding regimes are in place.
- The trust has changed its catering supplier and was reporting higher satisfaction with the quality of food.

Patient outcomes

- There were no Tier 1 mortality indicators for the trust, which meant that there was no evidence of risk for the composite indicator for in-hospital mortality and Dr. Foster composite of hospital standardised mortality ratio indicators (HSMR) or the summary hospital level mortality indicator (SHMI). There had been a reduction in the SHMI rate and the trust was now at 109, which is within the 'as expected' range.
- There were three mortality outliers for acute cerebrovascular disease, acute bronchitis and chronic obstructive pulmonary disease. Action plans were in place to address issues identified.
- There was a trust-wide programme of audits including national audits and local audits.
- Clinical audits took place to ensure that staff were working to expected standard and following guidelines. According to the trust's Annual Quality Account 2013/14 – 19 national clinical audits were reviewed and actions were identified as a result.
- The trust had highlighted that a number of national audits required additional focus to ensure that they remained on schedule for completion.
- DPOW was found to be performing better within expectations for all five of the Myocardial Ischemia (heart attack) National Audit Project indicators. The hospital was performing within expectations for the proportion of patients with a discharge diagnosis of nSTEMI who were seen by a cardiologist or member of their team. The hospital was performing within expectations for the proportion of patient with a discharge diagnosis of nSTEMI who were admitted to a cardiac unit or ward and the proportion of patient with a discharge diagnosis of nSTEMI who were referred for or had angiography.
- Actions from the National Diabetes Inpatient Audit led to the updating of Diabetes Hypoglycaemia pathways, the foot ulcer care pathway and new guidance had been approved for a new capillary blood glucose chart and managing inpatient glycaemia. Provision of educational presentations on how to establish the 'safe use of

insulin' online learning module and ongoing training to junior doctors, nurses and healthcare assistants on the importance of providing diabetes patients with supper had also been undertaken.

- Following a review into the concerns over the mortality performance data for the stroke unit at DPOW it was decided to centralise acute stroke patient care at one Stroke Hyper Acute service for the trust. Acute stroke services were moved the Scunthorpe General Hospital, although patients on the stroke pathway continued to be cared for at both hospitals. The stroke services at the DPOW were assigned a grade of D by the Sentinel Stroke National Audit Programme 2013 and the action plan from the audit was shared with staff across both hospital sites. Actions included the occupational therapy, physiotherapy and speech and language therapy managers to ensure junior team members were aware of the initial 72-hour assessment target and rehabilitation goal setting; a patient experience questionnaire for stroke patients to be developed at DPOW and stroke occupational therapy to look into setting up a regular multidisciplinary goal setting session, including other therapy staff.
- Staff were able to access local policies using the intranet and were aware of specific policies that affected the work carried out on the ward.
- The trust also participated in three Confidential Enquiries, including Subarachnoid Haemorrhage and alcohol-related liver disease, actions from both of which were ongoing.
- There was no evidence of increased risk of readmission after either an elective or emergency admission to the trust however site specific data was not available.
- Staff were able to access local policies using the intranet and were aware of specific policies that affected the work carried out on the ward.

Competent staff

- Ward managers were working towards making sure that nursing staff had the appropriate number of supervision sessions each year, in line with the trust policy, and were subject to an annual appraisal. According to dashboard information, there was still some work to do to achieve this. Supervision rates varied from ward to ward within the division, one ward had a rate of 18% compliance while other wards had the expected rate of 80%.
- Doctors were subject to the revalidation process. The trust-wide medical division annual appraisal rate for all staff was 61%. There was no hospital or discipline specific information available.
- Junior doctors received support, appraisal assessment and guidance to ensure they were competent to carry out their role. However, they did not always receive local training, for a number of reasons including being too busy with ward duties to attend.

Multidisciplinary working

- There was clear evidence of multidisciplinary working on the ward. There was regular input from physiotherapists, occupational therapists and other allied health professionals when required.
- There was evidence that the trust worked with external agencies such as the local authority when planning discharges for patients.

Seven-day services

- Access to diagnostic services was available seven days a week. Support services such as therapy services were not routinely available out of hours. Pharmacy was available six days a week.
- Some patients reported that there was very limited access to scans and tests on a weekend, with one relative stating, "Everything stops on a weekend, don't have a stroke on a Friday. No scans etc, for our dad at weekends".
- Staff, both nursing and medical, reported that patients admitted prior to a bank holiday could potentially not be seen by a doctor on the ward for more than four days unless they deteriorated.

Are medical care services caring?

Good

Overall, patients were content with the level of care they received from staff, although a number commented that staff did the best they could despite how busy they were and the pressure on them. Patients raised no concerns about their privacy and dignity being compromised and on the whole staff were thought to be polite, patient and caring.

Most patients were not actively involved in discussions about their treatment however they did not feel that this

was a concern. Some patients had been very involved in discussions about their future treatment needs. Patients were able to access support services, such as counsellors, psychologists and Macmillan practitioners.

The trust response rate for the friends and family test was poor and staff stated that in the past they had not always given out cards for patients to complete. This had changed recently and staff were encouraging patients to complete the comment cards.

Compassionate care

- From analysis of the CQC Intelligent Monitoring Report there was no evidence of risk regarding compassionate care, meeting physical needs, patient overall experience, treatment with dignity and respect and trusting relationships.
- The 2013 CQC adult in patient survey showed that the trust was average when compared with other trusts in eight out of the 10 areas reviewed.
- For the inpatient survey friends and family test the trust performed above the average for three of the four months reported, with October scoring the highest. The trust response rates were significantly lower than the national average indicating that scores are less likely to be representative.
- The 16 patients we spoke with were happy with the care and compassion they received on the ward.
- Patients believed that staff cared for them very well despite the pressure they were under and how busy they were on the wards however they felt that staff could not always meet their individualised needs.
- Throughout the inspection we saw patients being treated with compassion and respect and their dignity was preserved.
- Call bells on the ward were mostly answered promptly however we did notice that some patients' call bells were not within their reach. There were, however, occasions when call bells went unanswered for significant periods because staff were busy assisting other patients.
- Hourly roundings had been introduced to some wards to make sure that staff were aware of any emerging needs patients had.
- Patient-led assessment of the care environment (PLACE) showed that Diana Princess of Wales hospital scored 80.8% for privacy and dignity.

Patient understanding and involvement

- Patients on the whole felt that they were listened to by staff and some were aware of what was happening in their patient journey.
- Most patients hadn't been involved in formulating their care plans but they were aware of what treatment they would be having, and why. Some patients reported that medical staff had spent time with them, listened to them and discussed treatment options. The level of patient involvement varied between wards.

Emotional support

- Patients reported that the felt able to talk to ward staff about any concerns they had either about their care, or in general.
- There was information within the care plans to highlight whether people had emotional or mental health problems.
- Patients were able to access counselling services, psychologists and the mental health team.
- There were relatives rooms available where private discussions and sensitive conversations could take place.

Are medical care services responsive?

Requires improvement

Diana Princess of Wales Hospital offered a variety of medical specialty services. However, the designation of the specialty of some of the wards did not accurately reflect the actual type of patients treated.

There were times when patients were transferred between wards and to different sites late at night and early in the morning however the majority of patients were transferred after 7am and before 9pm.

The health needs of most patients were met and there was access to specific support services such as mental health services and therapy support. Patients whose first language was not English were able to communicate using interpreting services and there was some patient information available in different languages. Sometimes people's individual dietary needs were not met.

In the past, the trust had been poor at dealing with concerns of patients via the PALS service; however, this had improved recently with the appointment of a clinical

member of staff. Patient experience videos were also being trialled as a way of engaging with staff to help them understand the impact of poor care on patients. Some patients did not feel as though they were listened to and most of the patients we spoke with had not been given any information about the complaints process within the trust.

Service planning and delivery to meet the needs of local people

- There were a number of different wards at Diana Princess of Wales Hospital covering a number of different medical specialties including cardiology, respiratory medicine, endocrinology, gastroenterology, rheumatology, elderly care and stroke.
- Some wards were designated and specialist medical wards however the vast majority of the patients were Care of the Elderly patients. There was a concern that the staffing establishment reflected the acuity of for example endocrinology patients and did not accurately reflect the actual acuity of patients on the ward who were elderly and often frail. This meant that there was the potential that staffing levels were too low.
- Between 1 December 2013 and 27 February 2014 extra staff were brought in to assist wards on 39 occasions because of the increase acuity of patients.

Access and flow

- There was no data specific to this hospital about bed occupancy levels however the latest data provided to us by the trust showed that occupancy levels were around 81%, lower than the national average of 87.5%
- Patients on the medical wards were either admitted via A&E, after referral form their GP or electively.
- Information provided by the trust regarding hospital transfers, showed that most patient transfers to other sites took place between the hours of 7am and 9pm (70%) however 11% of patients were transferred between the hours of midnight and 7am and 19% of patients were transferred between 9pm and midnight.
- A critical care outreach nurse we spoke with felt there were some problems with inappropriate patient transfers between medical and surgical ward; they provided details of one recent case where an elderly patient was moved from the medical ward they were in at 4am to a surgical ward to make way for a medically unwell patient; the following day they needed re-admitting back to the medical ward because they too were unwell.
- The bed management team, which included matrons, worked closely with wards to try and ensure patient flow.
- Daily board rounds were undertaken and involved members of the multidisciplinary team.

Meeting people's individual needs

- The trust had a dementia strategy in place, with an accompanying action plan and was work in progress. The action plan was monitored by the Quality and Patient Experience Committee. A quality matron had been given the lead for dementia and dementia champions had been identified across wards.
- The trust was working towards achieving a nationally agreed dementia CQUIN (Commission for Quality Innovation – a payment reward scheme agreed by local commissioners aimed at encouraging innovation), for which it was required to ensure that patients were identified and assessed on admission with regards to dementia.
- Dementia Friends training had been delivered to some staff, including the trust board by the Alzheimer's Society. Staff we spoke with had an awareness of how to support people living with dementia. Dementia training was being rolled out across the trust but was not mandatory. We were unable to access ward specific information about the number of staff who had undergone dementia training.
- The trust had access to interpreting services using a three-way telephone service. Some leaflets and patient information was available in different languages on request but was not routinely available on the wards.
- The trust had a learning disabilities team that staff could contact if they needed advice. The carers of people with learning disabilities were encouraged to stay with the person to support the person and make sure that their hospital admission was the least disturbing possible.
- The wards were able to request extra staff called sitters to support people who were displaying challenging behaviour, who were wandering or who needed closer observation however there were not always staff available to do this, particularly during the day. 'Sitters' were easier to access at night time. Information from the trust regarding nurse expenditure showed that sitters were used on 59 occasions in the trust between 1 December 2013 and 27 February 2014.

Medical care (including older people's care)

Learning from complaints and concerns

- Staff were informed about the learning of complaints and concerns. Information was disseminated to staff at ward meetings.
- A newly appointed clinical staff member had joined the PALS team to assist with feeding back to wards. Staff in the PALS team and wards found this to be effective and beneficial.
- Patients were not aware of the complaints procedure and were not routinely given information about how to complain. The majority of patients and relatives however felt that they could raise concerns and be confident that they would be listened to on this ward.

Are medical care services well-led?

Requires improvement

Staff at Diana Princess of Wales hospital reported that they felt well supported by their managers and that there was an open and just culture when things went wrong. Most were aware of the future vision of the trust and felt that the executive and senior management of the trust were accessible.

The trust had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital. Patient engagement was improving and there were a number of initiatives in place to further improve engagement however patients and relatives were not routinely made aware of the complaints process while on the wards.

Although the division was aware of many of the risks that we identified we did not feel that these had been adequately addressed at the time of our inspection.

Vision and strategy for this service

- The trust had a clear vision and strategy.
- Staff on the wards were aware of this strategy and supportive of the direction of the trust.

Governance, risk management and quality measurement

- Wards used a quality dashboard and safety thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action was taken to improve performance.
- Trust-wide quality matrons were employed to lead the drive to improve quality.
- There were regular governance meetings and the outcome of these was fed back to staff at ward meetings.
- The trust had a risk register which on review identified many of the risks CQC were identifying during our inspection such as about staffing levels however we were concerned that improvements had yet to be made to the service despite their awareness.

Leadership of service

- Staff reported that on the whole they felt supported by their line manager and senior managers.
- Staff felt that the executive team at the trust was visible and accessible and receptive to concerns being raised.
- Managers were encouraged to make decisions about their wards in a supportive way and had the freedom to make decisions using their own initiative.
- There was a management structure in place in the wards we visited. Wards had a band 7 ward manager. Ward leaders had supernumerary time. Matrons were in post within the directorate to oversee directorate operational issues and assist with arranging additional staff.
- Ward manager and leadership courses were available to staff.

Culture within the service

- Staff spoke mostly positively about the care they provided for patients on the ward.
- Staff and managers reported that there was an open and honest culture and accountability within the trust.
- There was good team working on the wards between staff of different disciplines and grades.
- Service level data was not available for specific wards however trust-wide results of the staff survey were poorer than the national average relating to staff being able to provide the care that patients needed.
- Although the trust was spread out over a large geographical area, staff still felt that they were part of the trust. They felt included.

Medical care (including older people's care)

Public and staff engagement

- The trust took part in the friends and family test however overall response rated for the trust were poor. We were unable to access data specific to wards at Diana Princess of Wales Hospital.
- There was information in about the Patient Advice and Liaison service (PALS) in public areas.
- Patients were not routinely provided with information about how to make a complaint.
- The trust was using patient stories as a way of trying to improve the quality of care people received and raise awareness of the impact that poor care can have on patients.

Innovation, improvement and sustainability

- Managers told us that they were supported to try new ways of working to improve the effectiveness and efficiency of the wards.
- Junior doctors undertook quality improvement and clinical audit work.

Surgery

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

Information about the service

This hospital provides a range of surgical services including general surgery, trauma and orthopaedics, urology, ear, nose and throat, and day surgery. There are six wards which provide surgical services at Diana Princess of Wales Hospital, with approximately 140 surgical inpatient beds. There is also a surgical assessment and short stay unit, and day surgery ward. There are eight theatre suites including designated emergency and trauma theatres. Day surgery is incorporated into these theatre suites.

We visited all of the six wards as well as day surgery and the surgical assessment and short stay unit. We also visited all of the theatre suites.

We talked with 25 patients, 10 relatives and carers, and 21 members of staff including matrons, ward managers, nursing staff (qualified and unqualified), medical staff both senior and junior grades, and managers. We observed care and treatment and looked at care records for 15 people.

We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, this hospital.

Summary of findings

The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. Equipment was appropriately checked and cleaned regularly. There was adequate equipment to ensure safe care. Records were adequately maintained. The directorate had a large number of vacancies for both medical and nursing staff, which resulted in a high use of bank, agency and locum staff. The trust was trying to actively recruit into these vacancies. The number of staff having received mandatory training was variable across the surgical directorate. Some areas such as general surgery was 51%. The compliance rate across all surgical specialities had improved throughout the past year. The World Health Organization safety checklist at this hospital was not fully embedded. Safety briefs prior to the start of theatre lists were inconsistent.

Surgical services were effective as the hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working and access to seven-day services. Effective pain relief and nutritional arrangements were in place. Patients received care and treatment from competent staff, although appraisal rates for staff were variable.

Surgery

The surgical services provided at this hospital were caring. Most patients we spoke with, the care we observed, and the results of patient surveys and the family and friends test, all indicated that most patients received caring and compassionate care.

We found services were responsive. Access and flow arrangements were in place and the hospital were mostly meeting people's individual needs. The orthopeadic unit had adapted the ward environment to help meet the needs of people living with dementia. The hospital could improve the number of Fractured Neck of Femur patients who had surgery within 48 hours.

Most staff reported good leadership at all levels within surgery however we were concerned that the risks associated with poor compliance of the WHO surgical checklist, although identified by the division had yet to be addressed fully.

Are surgery services safe?

Requires improvement

The environment on the surgical wards and theatres was clean and there was evidence of learning from incidents in most areas. Equipment was appropriately checked and cleaned regularly. There was adequate equipment to ensure safe care. Records were adequately maintained.

There were areas where surgery required improvement. The directorate had a large number of vacancies for both medical and nursing staff, which resulted in a high use of bank, agency and locum staff. The trust was trying to actively recruit into these vacancies.

The number of staff having received mandatory training was variable across the surgical directorate. Some areas such as general surgery was 51%. The compliance rate across all surgical specialities had improved throughout the past year.

The World Health Organization safety checklist was used at this hospital. Safety briefs prior to the start of theatre lists were inconsistent.

Incidents

- Between December 2012 and January 2014 the trust reported twelve Never Events relating to surgical areas. We saw serious incident investigations had taken place and actions identified and implemented to ensure that there was learning from the incidents. Eleven of the events were to do with the implantation of a wrong lens by the same locum surgeon during ophthalmic surgery.
- Most staff were aware of the Never Events and could describe how practice had changed as a result. For example, revised practice for completing documentation in a specific area were now in place.
- We found the reporting of patient safety incidents was in line with that expected for the size of trust.
- There had been 11 serious incidents reported trust wide for surgical areas between December 2012 and March 2014, 5 of these were reported for this hospital and were low risk.
- Staff said they felt confident to report incidents and were aware of how to complete this. Feedback was given to ward managers who confirmed that any themes

from incidents were discussed at staff meetings or displayed in staff rooms. Staff were able to give examples of where practice had changed as a result of incident reporting.
- Incidents were discussed at ward manager meetings and the surgical matron attends a monthly matron forum which had attendance from across three sites and promoted shared learning.
- Mortality and morbidity meetings were in place in all relevant specialities, with oversight from the Surgery and Critical Care Group Governance Committee. Mortality is a standing item at this governance committee. All relevant staff participate in mortality case note reviews and or reflective practice.

Safety thermometer

- Safety thermometer information was clearly displayed on information boards in every surgical ward. This information included avoidable falls and pressure ulcers. The trust was performing above the England average for new pressure ulcers and venous thromboembolism (VTE), and below the England average for falls from harm and catheter and new urinary tract infections.
- Each ward had a quality dashboard which included monitoring of safety thermometer information. Any areas for improvement identified were discussed with Clinical Governance facilitators and ward managers to produce action plans.
- Staff we spoke with were able to describe how a change in practice had improved the rate of avoidable falls, for example, the introduction of chair sensor pads for people at high risk of falling including people living with dementia.
- Risk assessments for pressure ulcers, VTE and falls were completed appropriately on admission.

Cleanliness, infection control and hygiene

- Ward and theatre areas appeared clean and we saw staff regularly wash their hands and use hand gel between patients. Bare below the elbow policies were adhered to.
- Infection control information was visible in all ward areas, with each ward having an infection prevention and control information board. This information included how many days a ward had been free from C. Difficile.
- MRSA and C. Difficile rates were within an acceptable range for the size of the trust.
- Infection control audits were completed every month which monitored compliance with key trust policies such as hand hygiene. Most areas within surgery demonstrated full compliance from April 2013 to present.

Environment and equipment

- The environment on the surgical wards and in theatres was safe.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the wards to ensure safe care.
- Resuscitation equipment and defibrillation machines were checked daily on most of the surgical areas.

Medicines

- Medicines were stored correctly, either in lockers by a patient's bedside or in a drugs trolley which was locked at all times. Fridge temperatures were checked daily on all eight surgical wards with the exception of two. The matron was aware and this was being rectified.
- Medicine charts were completed. Where medicines had not been administered as prescribed, codes and an explanation were completed to indicate the reasons why.

Records

- All records were in paper format. Nursing and health care professionals documented in the same place. Medical staff maintained separate records.
- Records were kept securely when not in use.
- Medical health records keeping standards were audited annually. The most current audit report identified no significant issues within surgery.
- Nursing staff audit two sets of records a month as part of an annual nurse documentation audit, as well as reviewing ten sets of records every month as part of each ward's quality dashboard. These did not identify any significant issues.
- All surgical wards completed appropriate risk assessment. These include risk assessments for falls, pressure ulcers and malnutrition. Risk assessments we reviewed were comprehensively completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately. We saw examples of patients who did not have capacity to

consent to their procedure, appropriate mental capacity assessments were completed. Staff could describe how and when the Mental Capacity Act 2005 would be applied, as well as deprivation of liberty safeguards.

Safeguarding

- The trust had a safeguarding adults policy and guidance which had been recently revised and was in draft form. All staff we spoke to were aware of this policy and guidance and could describe how to report a safeguarding issue and the role of the local safeguarding adult services.
- Compliance with adult safeguarding level 1 training ranged from 58% to 100% across all surgical areas at this hospital.

Mandatory training

- We looked at staff mandatory training records. Overall, trust information for this hospital showed that in theatre compliance rate was 64%, surgical wards was 74%, orthopaedic (including medical staff) was 66%, and general surgery (including medical staff) was 51%.
- The compliance rate across all surgical specialities had improved throughout the past year.

Management of deteriorating patients

- The surgical wards use the National Early Warning System (NEWS) scoring system, a recognised early warning tool for the management of deteriorating patients. Wards use an electronic system to records patient's vital signs, and this is used for early identification of a deteriorating patient. The electronic board will inform staff if a patient's vital signs are deteriorating.
- There were clear guidelines for escalation. Staff we spoke with were aware of the appropriate action to take if patients scored higher than expected.
- The World Health Organization Safety Checklist was used at this hospital. We observed it being used in the theatres we visited. A recent audit performed by the trust showed that compliance with the sign-in, sign-out process was around 74% and 80% respectively. This is a step introduced by the trust to improve the safety processes within theatre.
- Safety briefs prior to the start of theatre lists were inconsistent. Staff said that, at times, there was lack of clinician engagement with this process.
- The hospital has actions in place to help address this by introducing a zero tolerance framework and increasing staff education and awareness.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. Work had recently been undertaken by the trust to reassess the staffing levels on wards and increase them. This was to ensure that staffing establishments reflected the acuity of patients.
- Ideal and actual staffing numbers were displayed on every ward we visited.
- All of the surgical wards and theatres had vacancies for trained nurses. The vacancy rate was around 9 WTE for qualified nurses in surgical areas. There were no significant vacancies for health care assistants. The trust was actively recruiting into these posts.
- Bank and agency staff were used to fill any deficits in nursing staff numbers. Staff could also work extra hours. Agency use was low, with the preferred option being staff working extra hours and the use of bank staff.
- All bank and agency staff completed an appropriate local induction on arrival for their shift.
- Nursing handovers occurred twice a day using patient information from the ward electronic system. This was detailed, comprehensive and identified any risks regarding patient care.

Medical staffing

- Surgical consultants from all specialities were on call for a 24-hour period.
- There were around 11 medical staff vacancies at junior, middle grade, and consultant level across the surgical areas. These were filled by regular locums or covered by medical staff already working in the directorate.
- Junior doctors had some concerns about the level of medical cover and the number of patients they were responsible for from midnight on weekdays and from 7pm at weekends. They provided medical cover for general surgery, urology, orthopaedics and ear, nose and throat. A specialist registrar and consultant were on call and available.
- Managers we spoke with confirmed that an additional junior doctor had been recruited to support out of hours activity in surgery.
- Medical handovers involved both formal face-to-face and telephone handovers. Medical staff we spoke with said that the handover process was good and provided them with the required patient information.

Surgery

Major incident awareness and training

- The trust employed a resilience manager and had plans in place to manage unexpected or unprecedented events which would enable services to continue to be delivered.
- The trust had a business continuity plan dated 12 November 2013 and an overarching business continuity policy dated 25 April 2014. Key functions were set out in the plan in order of priority and these included bed management and site management. The plan outlined specific risks and a business impact analysis was included. Recovery time objectives (RTO) and maximum tolerable periods of disruption (MTPD) were not specified.

Are surgery services effective?

Good

Surgical services were effective as the hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working and access to seven-day services. Effective pain relief and nutritional arrangements were in place. Patients received care and treatment from competent staff, although appraisal rates for staff were variable.

Evidence-based care and treatment

- Emergency surgery was mostly managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery. Surgery out of hours was consultant-led and delivered. Emergency theatre lists were available every day and night.
- There were no written protocols for deferring elective activity to prioritise unscheduled emergency procedures. There was guidance available in the escalation and surge policy.
- Policies are based on NICE and Royal College guidelines.
- The trust's quality and audit department completed audits to assess compliance with policies and procedure.
- Ward managers undertook regular audits (hand hygiene, records, falls). We saw that action was taken where issues were identified, for example increased staffing and introducing link roles.

Pain relief

- Patients were assessed pre-operatively for their pain relief post-operatively.
- Pain assessments were routinely carried out for patients and recorded.
- There was a dedicated pain team. A clinical specialist also available as well as being on call during weekends.
- Enhanced recovery pathways were used in elective orthopaedics as well as some general surgery.
- Most patients reported their pain was well controlled.

Nutrition and hydration

- Nutrition and hydration assessments were completed on all appropriate patients in the care records reviewed. These assessments were detailed and used the Malnutrition Universal Screening Tool (MUST).
- Care pathways for nutrition and hydration were in place and had been comprehensively completed.
- We observed care rounds where patients were offered a drink. Where appropriate, we observed drinks within easy reach of patients.
- We observed that nutritional and fluid intake was monitored where appropriate.
- Patient-led Assessments of the Care Environment (PLACE) scored this hospital 57.7% for food. The trust has since changed its catering supplier. Patients had no concerns about the quality of food.
- Dietitian advice and support was available if a patient was at risk of malnutrition.

Patient outcomes

- Patient Reported Outcome Measures for surgery were within expected limits.
- There were no current CQC Mortality Outliers relevant to surgery.
- The directorate participated in all national audits that it was eligible for and, overall, performance was satisfactory.
- The trust's performance for two of the five national bowel cancer audit project indicators was found to be better than expected (number of cases that had a CT scan reported), or tended towards better than expected (data completeness for cases having major surgery).

Surgery

- This hospital participated in the National Hip Fracture Database. Findings from the 2013/14 report showed that this hospital was improving in areas such as patients being assessed pre-operatively by an Orthogeriatrician, and had areas where performance had decreased such as patients admitted to an orthopaedic ward within four hours. The hospital had an action plan in place to address any issues.
- Day case surgery was performed below national expectation at around 83.5% of cases from March 2013 to March 2014. The British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases.

Competent staff

- We looked at medical and nursing staff appraisal records. Compliance rates for nursing staff having appraisals varied between wards and theatres from 27% up to 93%. Compliance rates for medical staff varied from 56% up to 100%.
- Ward managers told us of the actions in place to improve these compliance levels. For example, arranging dedicated time out to complete appraisals.
- Revalidation processes for nursing and medical staff were in place and up to date.

Multidisciplinary working

- Each ward had the input of a physiotherapist and occupational therapist during weekdays.
- The physiotherapists and occupational therapists worked closely with the nursing teams on each ward and described the multidisciplinary working as "fantastic". They used the same documentation as nursing staff and daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on each ward during weekdays and on a Saturday morning.
- The directorate worked closely with local authority as part of discharge planning.

Seven-day services

- On-call consultants completed ward rounds at weekends. They reviewed all patients. On call consultants provided support out of hours.
- Physiotherapy was available on a Saturday morning and was on call out of hours. There was no occupational therapy service at weekends.
- Pharmacy input was available on a Saturday morning. Wards could access an on-call pharmacist out of hours. Wards had a supply of stock take home medicines to enable patients to be discharged on a weekend, as well as an having access to an emergency supply of medicines if required.
- Radiology was available on call at weekends and out of hours and there were arrangements in place to access scans.

Are surgery services caring?

Good

The surgical services provided at this hospital were caring. Most patients we spoke with, the care we observed, and the results of patient surveys and the family and friends test, all indicated that most patients received caring and compassionate care.

Compassionate care

- Throughout our inspection we observed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly and patients we spoke to told us "staff are excellent", and "you can't fault them".
- We saw that comfort rounds were undertaken.
- We saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity.
- There were facilities on every ward for staff and relatives to have more sensitive conversations if required.
- Ward managers confirmed that if patients were very unwell, visiting times would be flexible.
- There was a lack of privacy in the check in area within theatre. There was no screened or curtained area for patients arriving on a trolley; the seating area for ambulant patients was in the same area so there was no privacy from each other or staff passing by.
- The trust's friends and family test response rate was significantly lower than the England average. Ward managers and the matron were aware of this and had introduced ways to help increase these response rates, including ward clerks proactively giving the document to patients as part of the discharge process and placing it on meal trays.
- There were no surgical wards that people would be "unlikely" or "extremely unlikely" to recommend.

Surgery

- The 2013 CQC adult in patient survey showed that the trust was average when compared with other trusts in eight out of the 10 areas reviewed. One of the areas the trust was below average was in operations and procedures, in terms of being given an explanation of what would happen before an operation or procedure and being told what to expect to feel this.

Patient understanding and involvement

- Patients and relatives stated they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- Ward managers we spoke with told us that they are always visible on the wards so that relatives and patients could speak with them.
- Ward information boards displayed who was in charge of wards for any given shift and who to contact if there were any problems.

Emotional support

- Patients said that the felt able to talk to ward staff about any concerns they had either about their care, or in general.
- There was information within the care plans to highlight whether people had emotional or mental health problems.
- Clinical nurse specialists in areas such as pain management and surgery were available to give support to patients.
- Patients were able to access counselling services, psychologists and the mental health team.

Are surgery services responsive?

Good

Overall, we found services were responsive. Access and flow arrangements were in place and the hospital were mostly meeting people's individual needs. The orthopeadic unit had adapted the ward environment to help meet the needs of people with dementia.

Service planning and delivery to meet the needs of local people

- The trust had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue.
- Staff had a good understanding of this procedure and were aware of their role in this.
- During busy times the bed availability was displayed on the trust's intranet.

Access and flow

- Referral to treatment times in less than 18 weeks for admitted completed pathways for this hospital was 87% against a target of 90%.
- Between October 2013 and December 2013 the trust's bed occupancy rate was 77.1% which is below the England average of 85.9%. The trust's bed occupancy averages have been consistently below the England averages over the period 2001 to 2013.
- There was a dedicated surgical assessment unit. This unit accepted patients by direct referral from the GP, A&E, and Outpatients. Staff we spoke with said that the maximum stay in this unit should be 72 hours but patients often have to stay longer which caused problems with patient flow.
- There was a day surgery unit and a pre-assessment service. Pre-assessment was routine for all elective admissions
- The bed management team worked closely with wards to try and ensure patient flow.
- The discharge planning process commenced at the pre-assessment stage, and for emergencies, at the admission stage.
- Daily board rounds were undertaken and involved members of the multidisciplinary team, for example physiotherapists and occupational therapists.
- Staff said that discharges could be delayed due to the lack of intermediate care beds. The trust is working with the local clinical commissioning group to address this issue.
- Electronic GP discharge summary was in use within surgical ward areas. Staff reported no delays with this process.
- The trust scored similar to expected when compared to other trusts regarding the proportion of patients whose operation was cancelled.
- Elective cancellation rates on the day of operation at this hospital was similar to expected between April 2013 and March 2014, with approximately 164 out of 535 operations being cancelled for non-clinical reasons. Other reasons were patient cancellations and clinical reasons.

Surgery

- The trust scored similar to expected when compared to other trusts regarding the number of patients not treated within 28 days of last minute cancellation due to a non-clinical reason.
- There were no urgent operations cancelled more than once during 2013/14 at this hospital.
- At this hospital 73.9% of Fractured Neck of Femur patients had surgery within 48 hours during 2013. This was down from the previous year. The England average during 2013 was 87.3%.
- The directorate had an outlier guidelines which included criteria for the suitability of patients to be transferred. Between March 2013 and February 2014 the surgical outlier rate for this hospital was around 9%.

Meeting people's individual needs

- Support was available for patients living with dementia and learning disabilities. The unit had dementia champions as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- The trauma and orthopaedic ward had two bays dedicated for caring for patients with dementia. The ward manager told us that research and evidence based practice had been used to set up these bays to support caring for people with dementia. Appropriate signage and different colour paint had been applied to the walls. Equipment such as low-level beds and chairs, and black toilet seats had also been installed. Staff we spoke with stated that the introduction of these nursing bays had significantly improved the mood and behaviour of patients with dementia, which in turn helped patients to recover from their treatment more quickly.
- A translation telephone service was available so that patients who English was not their language could communicate. Within the department it was possible to request a translator.
- There were multiple information leaflets available for many different conditions and procedures. These could be made available in different languages.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they would speak to the person in charge of the ward who would try and resolve the issue. If it could not be resolved they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets and posters which were available on all wards.
- The surgical matron received all of the complaints relevant to her unit. She would then speak to the relevant ward manager and staff involved. She would also offer to meet with the complainant.
- Staff we spoke with gave us examples of how wards had learnt from complaints. Each ward used "you said, we did" to show patients and relative how complaints had resulted in improvements being made on wards.
- Discussion of lessons learnt were completed at the surgery and critical care clinical governance groups and quality and safety days.

Are surgery services well-led?

Requires improvement

Most staff reported good leadership at all levels within surgery however we were concerned that the risks associated with poor compliance of the WHO surgical checklist, although identified by the division had yet to be addressed fully.

Vision and strategy for this service

- Staff were clear about the provision of high-quality care.
- Senior managers could articulate the trust vision; this was less evident with more junior staff.

Governance, risk management and quality measurement

- Surgery and critical care clinical governance meetings were held monthly. These involved all three sites within the trust.
- Complaints, incidents, audits and quality improvement were discussed.
- Feedback from these meetings was given to ward managers at their weekly meetings.
- Managers could provide examples of where they had identified issues and taken action to address these.
- Wards used a quality dashboard and safety thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action was taken to improve performance.

Surgery

- A surgical risk register was in place. This had controls and assurance in place to mitigate risk. It was regularly reviewed.

Leadership of service

- Each ward had a band 7 ward manager. Most managers we spoke with had some supernumery time each week.
- Most band 7 ward managers had participated in a nursing leadership programme.
- There was a matron who oversaw the surgical areas. We were told that she was visible, coming on the wards at least once a day.
- Nursing staff we spoke with stated that they were well supported by their managers. These managers were visible and provided clear leadership.
- Medical staff we spoke with stated that they were supported by their consultants.
- The clinical leadership structure had recently changed and was not fully embedded. Some medical staff were unclear about the new structure.

Culture within the service

- Most staff reported a positive shift in culture in the last 12 months. They reported increased engagement and visibility of the Chief Executive and the board of directors. Staff said it was more of a listening organisation.
- Staff morale had been an issue in theatres. The directorate had conducted a morale barometer in this area to try and find out causes for this. Work was on going with this.
- Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority.
- There was good team working on the wards between staff of different disciplines and grades.
- Staff sickness absence rates between September 2011 and September 2013 was broadly in line with England average.

Public and staff engagement

- The trust's friends and family test response rate is significantly lower than the England average. Ward managers and the matron were aware of this and had introduced ways to help increase these response rates.
- There was information about the Patient Advice and Liaison service (PALS) in public areas.
- The trust was rated as better than expected or tending towards better than expected for eight of the 28 NHS staff survey key findings 2013. Areas in this range included staff experiencing harassment, bullying or abuse from patients, relatives or the public and percentage of staff reporting errors, near misses or incidents witnessed in the last month.

Innovation, improvement and sustainability

- Managers told us that they were supported to try new ways of working to improve the effectiveness and efficiency of the wards.
- There were some examples of innovation and improvement, such as the introduction of quality and safety days. However, the impact of these initiatives

Critical care

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

Information about the service

Diana Princess of Wales Hospital has a seven bedded critical care unit (ITU) which includes two side rooms, one with bi-directional flow; there is also a four bedded high dependency unit (HDU). The ITU comes under the critical care directorate and the HDU sits within the directorate of medicine.

During the inspection we visited the ITU and HDU and spoke with a range of staff, patients and families. We also reviewed documentation, some patient records and observed care.

Summary of findings

The findings of our review of the critical care services are mixed. There were marked differences between the critical care unit (ITU) and high dependency unit (HDU) and also between nursing and medical leadership. Nursing leadership and nursing care on the ITU were to a good standard but the nursing leadership on the HDU was weak. Nursing staff on the HDU worked hard to provide suitable levels of care but the working practice arrangements did not positively support their work which negatively impacted on patient care.

There was insufficient medical leadership across the ITU and HDU the symptoms of which included the lack of pace in keeping up with nationally-recognised, best-practice guidance and the fragmented medical care provided to patients on the HDU. The HDU was a particular concern, especially in terms of the care provided to non-respiratory level 2 patients. The operational policy in place for the HDU did not match the existing working arrangements and the consistency of care and level of consultant input was below par. This in turn had significant patient safety implications particularly out of hours and at weekends.

In terms of nursing care on the ITU, care and treatment followed nationally-recognised, best-practice guidance and such guidance was up to date and easily accessible. In relation to medical practice, some guidance on the unit was not up to date.

Critical care

Outcome data for patients on the ITU was mixed. The HDU did not collect such data which dramatically reduced the ability to assess and benchmark patient outcomes.

On both the ITU and HDU we found staff, particularly staff in direct contact with patients, to be compassionate and respectful to patients and families. We observed staff being equally caring to those patients who were ventilated and who would not have been aware of their surroundings.

Are critical care services safe?

Inadequate

Reported incident numbers were comparatively low for this hospital in ITU and HDU and the vast majority were graded as low or very low risk. Safety thermometer data showed that harm to patients was low, for example, with falls, pressure sores and infections. This positively reflected on the standards of care in specific areas and good nursing practice.

The main concerns related to some aspects of medical practice and leadership and overall working arrangements on both the ITUU and HDU. There were also concerns about nursing leadership on the HDU and the lack of support provided to junior nursing staff. The medical rota for the ITU did not promote consistency of care and the consultant reviews of patients at weekends was not adequate. In addition, patients were not always assessed by a consultant within 12 hours of admission. We also had concern about medical practice not keeping pace with nationally-recognised, best-practice guidance and the precedence placed in working towards such practice. Of greatest concern, was the safety of non-respiratory patients on the HDU, particularly out of hours and weekends and bank holidays. There was widespread confusion about 'ownership' of level 2 non-respiratory patients which created significant confusion and frustration for nursing staff. The processes in place did not promote efficient working which put patients at risk of delayed and inadequate treatment.

Incidents

- There were a total of 232 critical care incidents recorded across the trust between 1 April 2013 and 31 March 2014; about 19 reported incidents per month. The vast majority of incidents were recorded as low or very low risk. 53 of the incidents occurred at the Diana Princess of Wales (DPoW) hospital which includes a seven bedded ITU and four bedded HDU. 179 incidents were recorded at Scunthorpe General Hospital (SGH) where there is an eight bedded ITU. Some themes occurring from reviewing the incidents were around pressure area care, failings with air mattresses and delays in concerns about patient safety/wellbeing being escalated.

Critical care

- The above figures show a comparatively disproportionate amount of incidents and/or incident reporting and it is unclear why the incident report numbers at SGH are significantly higher than at DPoW.
- There were no Never Events for critical care between December 2012 and January 2014.
- The serious incidents for anaesthesia and pain management across the trust between June 2012 and July 2013 equalled 8; 6 moderate concerns, 1 abuse, 0 severe and 1 death.

Safety thermometer

- We noted that the ITU had safety thermometer information displayed on the unit and the data showed no pressure ulcers for the previous four months, no falls, no urinary tract infections, no venous thromboembolism (deep vein thrombosis) and 100% harm free for the previous four month.
- On the HDU there was no quality indicator information displayed or safety thermometer data.
- We spoke with nursing staff on the HDU and there was no awareness of numbers of pressure ulcers, falls, complaints or other key information that indicated the quality of outcomes for patients.

Cleanliness, infection control and hygiene

- We observed hand washing compliance on the ITU, particularly for nurses and doctors.
- If there was patient contact, nursing and medical staff, cleaned their hands appropriately the majority of the time, using either soap and water or alcohol hand-rub.
- However, we observed several instances where staff came in to contact with patients' immediate environment and hand-washing was not performed afterwards; this increases the risks of cross contamination between environments and/or patients/ staff.
- On the temporary HDU there was one hand wash basin for three beds and a hand wash basin in the one-bedded side room. The number of sinks overall was not ideal but a new unit was being developed.
- The ITU had two hand wash basins for five bed areas which was not ideal; such a low sink-to-bed ratio affected the ease at which people could access a sink.
- All staff followed the trust's uniform policy in clinical areas and had rolled up sleeves or wore a short sleeve top; staff did not wear wrist watches.
- The environments of all the critical care and high dependency units we visited were visibly clean including horizontal surfaces and high-contact surfaces/ equipment touched by staff and patients.
- We observed the use of personal protective equipment (PPE) on the ITU; mainly aprons. Their use was not consistent; some staff wore an apron for all close contact with the patient and some would only where aprons for certain close contact procedures
- The trust's infection rates for C.difficile and MRSA infections were within a statistically acceptable range for the size of the trust. In relation to the ITU, there was one MRSA blood infection sampled from a patient in December 2013; a route cause analysis (RCA) was conducted and it was noted as an unavoidable infection.
- Learning occurred from the RCA including ensuring correct documentation was used for blood cultures and staff were reminded about the trust's MRSA screening policy.

Environment and equipment

- We spoke with staff about the general environment and equipment on the ITU. The blood gas machine on the unit was dated but the trust board had recently approved a contract for new machines and associated consumable supplies.
- Syringe drivers on the ITU were relatively new and these had been replaced in 2013.
- Humidifiers on the ITU were also relatively new.
- The trust had a Medical Device Evaluation and Replacement Process and all equipment was risk assessed and evaluated by the Equipment Group.
- A staff nurse on the ITU informed us that the ventilator machines were ten years old but were serviced regularly and worked effectively.
- Monitoring equipment on the HDU was described by the nursing staff as old and the unit was awaiting new monitors as part of the refurbishment of HDU; work had started on the new unit. Bed spaces were supposed to be checked daily, including oxygen and suction; this was not done on 25% of the days in April 2014.
- We observed resuscitation equipment on the ITU and HDU; necessary emergency equipment was in place and daily check processes were in place. On the ITU the defibrillator was checked daily. However, checks had not been done for 20 and 23 March 2014.
- The ECG electrodes were also out of date.

- Staff we spoke with on the ITU said there were not enough plug sockets so extension leads needed to used; this created some safety concerns because several electrical leads were on the floor around the bed space and hung over drip stands; they were also a trip hazard.
- The new HDU was reviewed; this is a seven bedded unit consisting of two rooms of three beds (male and female) each containing bathroom facilities and a single side room. There appeared to be adequate space around the beds but a lack of storage space overall.

Medicines

- We checked medicines on the ITU and HDU; they were stored correctly in locked cupboards and fridges where necessary. Fridge temperatures were checked and recorded, and were within the necessary limits.

Records

- We reviewed nursing records/documentation on the ITU and it was comprehensive and included the relevant care pathways, evaluation of care, observations, accurate fluid balance recording and other general assessments.
- Nursing documentation used was in-line with best-practice recommendations.
- Medical records on the ITU were completed daily and were clear to follow.
- Medical records on the HDU were completed accurately but revealed a lack of consultant and doctor input daily and particularly at the weekend, this included bank holiday weekends.
- There was a nursing discharge summary but no medical version accompanying the patient to the ward when discharged.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff could describe how and when the Mental Capacity Act 2005 would be applied, as well as deprivation of liberty safeguards.
- We spoke with the ICU nursing sister about restraint and there was a hospital policy on restraint.
- Restraint on the ITU was rarely used.
- Mitts were occasionally applied to patient's hands to prevent them from pulling out drips and other medical devices and the nurses described the correct process for reaching best interest decisions.

Safeguarding

- We spoke with nursing staff on the HDU and ITU about safeguarding and staff were aware of how to escalate concerns.
- Staff felt confident in being able to recognise a potential safeguarding concern and escalate appropriately where necessary.
- The trust had a safeguarding policy in place that was easy accessible by all staff.

Mandatory training

- We spoke with the nursing clinical educator and they closely monitored nursing staff training and competencies on the ITU; nursing staff on the ITU were 85% compliant with mandatory training.
- Mandatory training figures for the HDU were at 75%, 10% lower than those for the ITU.
- The clinical educator for the ITU and HDU had recently moved in to another role and their position was being advertised.
- The newly advertised role was not intended to be the same as the original post but it was still to include clinical education.

Management of deteriorating patients

- From discussions with ward nursing staff and junior doctors, it was felt the early warning score system in place at the hospital had become well embedded over the past year.
- Nursing staff, on the whole, sought advice from medical staff when warning scores were showing patients to be deteriorating.
- Some junior doctors felt clinical judgement with nursing staff could be improved and staff should be aware not to solely make judgements on the overall warning score but also be vigilant about the individual elements that influence the score. For example, one junior doctor described how a patient had a moderate warning score but the patient's blood pressure was worryingly low; the low blood pressure alone should have prompted more urgent escalation and prompter medical review.
- There was no designated medical team overseeing the patients on the HDU and nursing staff we spoke with were regularly uncertain about which doctor to call for which patient; this was a concern particularly in an emergency situation.
- During the inspection we overheard a nurse on the telephone for about 30 minutes attempting to get medical advice; the nurse had to bleep several doctors

to gain a decision about a patient's change in condition. The nurse was asked several times to try different doctors; the process was not efficient. The process was even more challenging out of hours and at weekends.

- A registrar we spoke with acknowledged that the nurses did struggle to get hold of doctors and investigations were sometimes difficult to get done.
- It was stated that radiologists would only ever speak with a consultant; this was not seen as a particularly helpful process.
- We spoke with the respiratory consultant lead for the HDU and it was clear they worked hard to ensure patients received safe care within the resources provided. We were informed that in the region of 75% of patients on the HDU were respiratory patients.
- The remaining 25% of patients on the HDU were non-respiratory patients and these patients were admitted and initially reviewed by acute care physicians.
- Respiratory consultants would review all respiratory patients. However, there was uncertainty as to who was responsible for the ongoing management of the non-respiratory patients; this was confirmed by both nursing and medical staff.
- All the respiratory consultants conducted daily ward rounds. Ward rounds were not being conducted by a consultant at weekends. This resulted in the HDU patients not being seen by a consultant for the three days of the Bank Holiday weekend and regular review by any doctor was, at best, inconsistent.
- The lack of a designated medical team on the HDU taking ownership of the unit had an impact on the management of the deteriorating patient because there was no dedicated team responsible for each patient. Therefore, staff were unsure who to contact if a patient was deteriorating and thus the time taken for a doctor to review a patient would be unnecessarily delayed.
- The nursing sister on the HDU commented on the process for managing a patient who was rapidly deteriorating. If, for example, a patient was having problems breathing because of their airway, nursing staff were required to 'fast bleep' the registrar.
- Nursing staff acknowledged that out-of-hours discharges were not ideal and there were patient safety implications. Out-of-hours transfers were avoided if possible.
- The ITU provided data on the number of out of hours transfers but HDU did not monitor this or delayed discharges and readmission rates.
- There were also some general concerns about patients who were increasingly and regularly being transferred from ITU to wards at inappropriate times of the day such as at 21.00 despite the decision being made in the ITU on the morning ward round.
- A middle grade doctor (CT1) we spoke with on the ITU felt that picking up the deteriorating patient across the hospital site was better than before but it could still be improved.
- When patients were discharged to the wards there was no medical discharge document to act as reference for the receiving medical team.

Nursing staffing

- We reviewed nurse staffing rotas for the ITU for the months December 2013, January, February and March 2014. There was a suitable complement of nursing staff and agency or bank staff had not been used. Staff sickness levels were not excessive.
- Nursing staff we spoke with raised no concerns about nurse staffing levels or issues in relation to retention or morale.
- The nurse to patient ratios met the national standards of 1:1 on the ITU and 1:2 on the HDU.
- Nursing handovers on the ITU and HDU were at 7.30am and 7.30pm.
- We observed a nursing handover on the ITU; it was a full-team handover at the bedside and was sufficiently detailed.

HDU

- There was one substantive band 7 ward manager, supported by a substantive band 6 deputy manager. The ward manager was temporarily seconded for three days a week into a matron post between January and May 2014. The three days were backfilled by the deputy manager (band 6); we were told that the band 7 rarely visited HDU.
- The band 7 ward manager spent significant amount of time as shift manager and in their other role as matron.
- It was felt by senior medical staff that the HDU needed a clearer nurse command. The respiratory consultant lead and a registrar working on the HDU felt the nursing leadership on the unit was not ideal because the band 7 nurse's time was not dedicated entirely to the HDU.

- The diluted nurse leadership on the unit was felt to be a reason why there was not much outcome data for the HDU. ICNARC data was not being collected; this prevented important comparisons being made with other similar units especially in terms of patient outcomes.
- One nursing sister for the HDU said there were ten band 5 nurses (junior nurse grade) working on the unit and there were plans to increase this to 20 to staff the additional three beds.
- The nurse/patient ratio on the HDU was one nurse to two patients 24/7.
- Staff described how the outreach team were very supportive and so were the 'hospital at night' team.

Medical staffing

- We spoke with a consultant anaesthetist, middle grade (staff grade) doctor and two other middle grade (CT1 and CT2) doctors on the ITU about medical staffing and we also observed medical teams working on the ITU.
- We also spoke with nursing staff about medical cover and support for the unit and reviewed the on-call rota for the previous three months.
- We observed a morning medical bedside handover on the ITU which was completed promptly to enable the trainee doctor who had worked the night shift to finish on time; the handover took 30 minutes. The 30-minute medical handover, however, was also the ward round; the two were done together. In other similar units; it is common practice to conduct a medical handover followed by the ward round.
- The adequacy of a combined 30-minute handover and ward round is questionable as it provided limited assessment, management planning and discussion for each patient. The combined approach was not uniform across all medical staff and we were informed other consultants had separate handover and ward rounds.
- The ITU used an electronic handover system. The outgoing trainee had an electronic copy of the patient details for handover, which was updated for each handover. However copies of this weren't given to the incoming medical team, thus reducing the effectiveness of such a system.
- There were 14 consultant anaesthetists, three of whom did not take part in the on-call rota. We understood, that with upcoming recruitments, there would be 13 consultants taking part in the on- call rota, of which six will be intensivists.
- The daytime consultants covering the ITU covered one day at a time and on occasions, two different consultants covered one day. The failure of one consultant to cover for a longer period of time has the potential to adversely impact on the continuity of patient care and management. This was acknowledged by some of the nursing staff.
- A consultant anaesthetist we spoke with acknowledged the weaknesses with the current working arrangements but no active steps were being taken to resolve the issue. While recognised as being potentially an issue this wasn't being addressed because of the increase in on-call frequency that would ensue.
- We spoke with the associate director for surgery and critical care about the consultant working patterns and changes to existing practice were not planned; this was partly because critical care best-practice standards were not seen as mandatory.

HDU

- The patients on the HDU were level 2 patients and this included patients on vasoactive drugs (which effect heart contraction and blood pressure), non-invasive ventilation (ventilation provided that does not involve a tube inserted into the patient's wind pipe), continuous positive airway pressure (use of mild air pressure to keep the lungs open) and invasive monitoring (arterial or central venous line insertion to monitor vital signs).
- There were 3.5 whole time equivalent (wte) respiratory consultants, one was part-time. Medical cover was supported by acute consultant medical physicians.
- With one patient, we noted they had been admitted to the unit at 7.30am and they had not been reviewed by a consultant until after 3pm the next day. Critically ill patients (level 2 and 3) should be reviewed by a consultant twice daily.
- An acute physician reviewed patients on the day of their admission and was supposed to handover to the medical team the next day. Staff reported that this often did not happen which meant some patients were neither looked after by an acute physician or a specific medical team. In effect, this meant, on occasion, no one was looking after particular patients and the nursing staff were often unclear who to call.
- There didn't appear to be an organised approach to the overall management of patients on the HDU and the current system was not working safely or effectively. One

patient had not been reviewed over 30 hours and several patients' notes revealed no daily consultant input; this was not appropriate for the management of level 2 patients.
- A registrar we spoke with on the HDU described how there was sometimes confusion as to who was covering for the patients in terms of doctors; out of hours it was usually the medical registrar.
- The sister described how patients were admitted under a medical physician and this was most often different for each patient. There appeared to be complete confusion as to which consultant the medical patients were under.
- Anaesthetists did not have any input into the HDU.
- After 5pm.on the HDU, Monday to Friday, patients on the HDU were covered by a medical registrar; if a patient became very unwell there was a consultant physician on site up until 8pm. After 8pm the consultant physician on call would be approached.
- Out of hours there was very little consultant involvement in the admitting, discharging and management of patients on the HDU.
- The way in which the HDU medical cover was provided was confusing, inconsistent and in certain areas was unsafe; this was particularly so for non-respiratory HDU patients out of hours and at weekends. It was a level 2 patient unit that ideally should have been providing a consultant-led service; this wasn't the case.

Major incident awareness training

- Major incident training was covered at induction and via annual mandatory training.
- Staff we spoke with were able to describe the major incident policy and where to locate a copy.

Are critical care services effective?

Requires improvement

In terms of nursing care on the ITU, care and treatment followed nationally-recognised, best-practice guidance and such guidance was up to date and easily accessible. In relation to medical practice, some guidance on the unit was not up to date and some medical practice was not striving to follow the latest guidance, for example, in relation to the ventilation of patients with respiratory disease.

Outcome data for patients on the ITU was mixed. Importantly, mortality ratio figures compared with number of admissions to the ITU were not seen as an outlier but other data was not as re-assuring, for example, mortality rates for ventilated patients and in-hospital cardio-pulmonary resuscitation (CPR) rates. The HDU did not collect such data which dramatically reduced the ability to assess and benchmark patient outcomes.

The comments above highlight a lack of impetus in terms of implementing best-practice guidance, particularly from a medical perspective, which in turn could have safety implications for patients.

Evidence-based care and treatment

- In relation to nursing and the critical care unit, we found care and treatment was evidence-based and the guidance was easily accessible at each bedside.
- Nursing policy folders were up-to-date and followed best-practice guidance.
- On the HDU, in relation to nursing, there were no evidence-based critical care guidelines consistent with nationally-recognised ITU standards.
- In relation to medicine and the critical care unit, we found no available operational policy and evidence-based guidance and documentation was not up to date and was disorganised.
- There were examples where we had concerns about adherence to/awareness of the latest evidence-based critical care medical guidelines. For example, there was worrying misunderstanding towards the latest practice of ventilating patients with respiratory disease. There was no evidence of protective lung ventilation in the form of guidelines, knowledge of staff and practice.
- Contrary to best-practice guidance, there was evidence of tidal volumes of greater than 12mls/kg being used to ventilate one patient. As discussed previously, the mortality rate for ventilated patients on CITU has been, in the main, consistently higher than that of other similar units.
- Out of necessity some patients had to be transferred to another Critical Care Unit. We were informed by the trust following the inspection that there was a transfer checklist and documentation to record observations and events that take place during transfer. However, we did not see this in use. New trainees had no teaching or training on transferring patients.

Critical care

- A few guidelines were available on the ITU, most of these were not in the trust format, were undated and did not have review dates on them.

Pain relief

- We spoke with a range of staff on the ITU and HDU and pain relief. Staff felt well supported by the pain team when required.
- The pain team provided adequate support to the ITU and no concerns were raised about inappropriate pain relief during our inspection of the ITU or HDU.

Nutrition and hydration

- Staff we spoke with described how dieticians visited the ITU on a regularly basis and/or as and when required.
- We noted from reviewing some patient records where dietetics had been involved in supporting patients in ensuring adequate nutrition and hydration.

Patient outcomes

- We reviewed the ICNARC data for the period 1 January 2013 to 30 June 2013. We noted that in-hospital cardio-pulmonary resuscitation (CPR) rates were consistently above the rates for other similar units. This could be an indication that some patients had deteriorated beyond acceptable levels on the wards before being admitted to the ITU or support provided to the wards from critical care trained staff was not always adequate.
- In relation to patients admitted on a ventilator (a machine that supports people to breathe), percentage unit mortality has been, in the main, consistently higher than that of similar units for a relatively long time and there was a comparatively high spike in numbers for quarter one of 2013. There didn't appear to be any purposeful steps being taken to tackle the consistently high mortality rates for ventilated patients and we had concerns during the inspection about medical practice in relation to care of the ventilated patient.
- Average length of stay for patients admitted on a ventilator was consistently lower than other similar units.
- Mortality ratio figures compared with number of admissions to the ITU were not seen as an outlier as compared to all other NHS adult, general critical care units and compared to other similar units for between 1 January 2013 to 30 June 2013.
- Post-unit hospital deaths showed a downward trend.
- Saving Lives High Impact Intervention data for ITU and the high dependency unit (HDU) for central venous catheter insertion for December 2013 showed 100% compliance for insertion and ongoing care. However, for the ITU, the required number of observations was not always met but this may have been because some lines were initially inserted in other departments.
- An area of non-compliance with the high impact intervention data related to the HDU and hand hygiene; where the observation percentage was 30%
- The High Impact Intervention audits across the critical care units were self-audit data. Compliance figures for central line insertion across all relevant wards within the hospital were 100% but we were unclear if there were other lines of assurance or peer observed audit information to qualify the 100% compliance figures.
- There was no outcome data, including mortality rates, for the HDU.

Competent staff

- There was good coordination of critical care training and education; 55% of nurses on the critical care unit had a specific critical care qualification.
- All of the ITU staff had been trained in intermediate life support.
- A staff nurse we spoke with was positive of the support and standard of training on the critical care unit. They showed us their comprehensive competency-based assessment portfolio for care of the critically ill.
- Newly qualified nurses starting on the critical care unit had an eight-week period where they were supernumerary and they were also allocated a mentor.
- 18 nurses on the ITU had a mentorship qualification.
- All staff had been trained in understanding the trust's early warning score processes; known as ALERT for qualified nursing staff and BEACH for healthcare support staff.
- We spoke with a newly-qualified ITU nurse and they were positive about the training they had received on the ITU; induction was also comprehensive.
- They had a portfolio to work through and this was based on nationally-recognised competencies.
- Staff development was supported by the Critical Care Network
- The newly-qualified ITU nurse described how all staff were supportive and there was good access to training aids such as e-learning.

Critical care

- On the HDU the nursing sister was unsure as to whether nursing staff had been through a critical care competency-based training programme. A new staff nurse on HDU had not been supported with a competency-based assessment portfolio. This could have a negative impact on patient care if nurses have not been assessed on key nursing components for the care of the critically ill.
- Training available for outreach nurses included non-invasive ventilation, train-the-trainer in relation to early warning score training (ALERT) and patient assessment.
- There was no formal teaching or training for any of the non-consultant staff in intensive care medicine (ICM). Doctors were able to obtain study leave without any problem. All consultants spoken to had received an appraisal within the last year.
- There was no evidence of any training in ICM for any of the doctors covering the HDU. There was no evidence of protocols or guidelines for invasive monitoring and use of inotropes for example.
- Medical staff had no training in transferring the critically ill patient.
- Medical staff felt that induction was adequate but sessions on maternity and ITU were not routinely arranged prior to being on call there, these had to be requested.
- Medical staff we spoke with described how there was limited formal teaching or training for non-consultant staff in intensive care medicine. However, following the inspection we were informed by the trust that teaching and presentations happened during anaesthetic audit meetings.

Multidisciplinary working

- We spoke with an outreach nurse for critical care and the service provided was seven days a week from 7.30am to 8pm.
- After 8pm there is support for patients provided by the 'hospital at night team.'
- In the region of 90%–100% of critical care patient discharges are followed up by the outreach.
- Follow-up clinics delivered by the outreach nurses have relatively recently been introduced for patients who have been on the ITU for more than three days.
- There was daily input from microbiology, physiotherapy and the dietician, and these were available for any problems that may arise throughout the day. There was daily input from pharmacy but they were not included in the ward round.

Seven-day services

- At weekends, on the intensive therapy unit, consultant ward rounds were completed once daily rather than twice daily as recommended nationally. This also meant that not all patients were reviewed by a consultant within 12 hours of admission (this is a national standard).
- A common theme coming from discussions with staff was that there were a limited number of doctors available to support the ITU and HDU out of hours. The middle grade ITU doctor also covered maternity, there was also a trainee covering theatres. The consultant was responsible for covering all three clinical areas. At busy times, and particularly when a patient required transferring to another hospital, medical staff maybe rather stretched. The consultants would willingly come in to the hospital if needed and very much disapproved if they were not contacted when required.
- The ITU was covered by anaesthetic consultants who are not necessarily trained in or kept up to date in critical care medicine. Most of the consultants did not have regular daytime sessions on the ITU. Several members of the medical and nursing staff felt that the decision making of the non-intensivist consultants was inferior to that of their intensivist colleagues.
- Out-of-hours imaging and pharmacy were all available. In addition, medical resonance imaging (MRI) was available 7.30am – 10.30pm seven days a week with facilities to ventilate patients.

Are critical care services caring?

Good

From our observations on both the ITU and HDU we found staff, particularly staff in direct contact with patients, to be compassionate and respectful to patients and families. We observed staff being equally caring to those patients who were ventilated and who would not have been aware of their surroundings.

Critical care

Patients and families we spoke with were positive about their experiences on the ITU and HDU and felt staff were caring and communicated with them well. We saw examples of patients being involved in making decisions about their care which supported the fact that staff respectful patient's decisions.

Compassionate care

- Patients we observed on the ITU and HDU looked comfortable and it was clear that personal care had been provided to a good standard.
- We observed nursing and medical staff on the ITU providing direct care to patients; we found staff interactions with patients and/or their relatives to be friendly, respectful and supportive.
- We also observed nursing staff support patients on the HDU and nurses were polite and respectful. One patient we spoke with said doctors were friendly but would sometimes have conversations at the foot of their bed almost as if they were not there.
- On the ITU and HDU, curtains were drawn around bed areas while care was delivered and privacy and dignity maintained.
- Some of the patients we observed were critically ill and were on ventilators. Staff were equally caring and respectful to those patients that may not have been fully aware of people around them.
- Staff would inform patients of what they were doing even when it was unlikely the person would be able to hear and/or understand what they were saying.
- We spoke with one family on the ITU and one family member said, "I'm happy with the care and communication on the unit and would be looked after on here myself."
- The same family member felt the unit should have a designated room for discussing patients' care with relatives. The current practice involved removing other relatives from the waiting room when situations arose which required privacy; this was confirmed by both nursing and medical staff. There are no overnight family facilities.
- The relatives also felt facilities for families could be better, for example, having a vending machine for tea and coffee.
- Senior nursing staff on the ITU stated that inpatient survey data showed that patients were, in the vast majority of cases, positive about their experiences on the unit.

Patient understanding and involvement

- Some of the patients we observed were critically ill and were on ventilators; this meant that direct interaction and involvement was difficult. We observed a nurse caring for a patient who had recently been ventilated and were drowsy. The nurse explained in detail what the plans were for their continued care and gained some acknowledgment from the patient; the nurse was caring and supportive.
- A family member we spoke with said staff were supportive and communicated with them and the family well.

Emotional support

- The patients and families we spoke with on the ITU felt the staff did all they could for patients and were very willing to listen to concerns.
- Patients also felt medical staff were supportive and made time to listen.
- Patients and/or relatives were provided with specific contact numbers if additional emotional support was required.

Are critical care services responsive?

Requires improvement

Data in relation to patient access and flow for the ITU was mixed. Average length of stay data and bed occupancy data was good. Delayed discharges were the main concern especially in terms of the negative impact this can have on patients. The critical care environment is not suitable for patients who are no longer in a critical condition.

Service planning and delivery to meet the needs of local people

- We spoke with a consultant doctor in the ITU about how the unit deals with busy times. They felt there were appropriate escalation processes in place and staff living close to the hospital could be called on where necessary.
- They also said that during busy periods patients were often found beds throughout the hospital to support the management of patient flow and release critical care beds; this sometimes involved using the recovery bays in the operating theatres.

Critical care

Access and flow

- Data presented by the Intensive Care National Audit and Research Centre (ICNARC) for the Intensive Care Unit (ICU) in relation to quality indicators and outcomes showed several trends.
- The ICNARC data we reviewed for the period 1 January 2013 to 30 June 2013 showed upward trends in relation to delayed discharges from critical care and out-of-hours discharges to the wards. There were examples where decisions to move patients off the unit had been made during the morning ward round but in other cases it was clear that the decision must have come out of hours.
- The latest bed occupancy figures for the ITU were 86% which is satisfactory. The previous three months figures were 78%, 89% and 89% bed occupancy respectively. There were no bed occupancy figures for the HDU.
- Length of stay was also regularly below average figures seen at similar units for admissions for patients admitted on a ventilator, with pneumonia, severe sepsis, elective and surgical admissions and trauma with perforation or rupture.
- The overall trend relating to average length of stay for the unit for all admissions was below those seen by similar units.
- In relation to delivery of care indicators, the unit had figures above similar units for early reported discharges and out-of-hours discharges; there was a moderate spike during quarter one of 2013 for early reported discharges.
- Out-of-hours discharges to the ward were regularly below the figures for similar units and this was true for reported delayed discharges. However, there has been a significant upward trend from late 2008 to quarter two of 2013; this has also been true for discharges delayed by four hours.
- Overall, the vast majority of delayed discharges were less than 24 hours, around 31%. The upward trend with reported delayed discharges indicates the increasing pressures and demand for general ward beds.
- The reasons behind the upward trend in out-of-hours discharges to the ward were multifaceted and nursing staff we spoke with on the unit presented their views but there was no definitive reason. Some nursing staff felt the central bed management control system did not prioritise available beds across the hospital site effectively and did not effectively consider patients' state of health.
- Nursing staff we spoke with described how available general hospital beds were often required for several patients at the same time and patients about to breach the A&E four-hour wait target often took priority. Because of this, unwell patients requiring a bed on ITU could be delayed and patients suitable for discharge from ITU also experience delays.
- One staff nurse felt that discharges from the unit and admissions to the unit were more regularly occurring later in the evenings. They described how the night site manager was able to get patients moving and queried why this couldn't happen sooner in the day. There was an indication that decisions weren't being made early enough in the day.
- Non-clinical transfers out has seen a steady increase from quarter two for 2012 and this indicates the bed pressures on the ITU and the increasing need for patients to be transferred to other hospitals because of a lack of critical care bed capacity.

Meeting people's individual needs

- Nursing staff we spoke with said that if patients had specific additional needs staff would willingly allow care workers and/or family to visit the unit out of usual visiting times.
- For patients with additional/complex needs staff encouraged families to provide extra support where appropriate.
- Families/carers were able, on occasion, to stay over at the hospital if necessary. Family members/ carers were provided with a recliner chair so they could sleep on the unit next to their relative.

Learning from complaints and concerns

- The ITU sister stated that there had been two complaints in relation to the unit in the previous 12 months; they were both about staff attitude.
- The complaints were openly discussed at staff meetings in order to engage with staff and ensure lessons could be learnt.
- The unit held communication meetings every month which included junior and senior nursing staff; these meetings regularly discussed complaints and concerns and any learning points.

Critical care

- There was an electronic critical incident reporting system which most staff didn't use because they felt they didn't get feedback. Staff preferred to use a paper system that fed directly into the anaesthetic department, from which they did receive feedback. There was joint anaesthetic clinical governance afternoons with the surgeons (nothing specific to ITU) where cases were discussed and audits presented every two months, these have recently been changed to safety days.
- There was no mortality and morbidity or clinical governance meetings for HDU patients.

Are critical care services well-led?

Inadequate

The governance and leadership for critical care was variable. From a nursing perspective, on the critical care unit, nursing leadership was good and staff felt engaged and positive about their work. Nursing staff on the HDU were not as positive and felt nursing leadership and support on the unit was lacking.

From a medical perspective, leadership was insufficiently evident. Roles did not seem clearly defined and there was a lack of direction for the service. This was evidenced with how the HDU was being managed.

Vision and strategy for this service

- Joint governance meetings were held monthly attended by senior nursing staff; these meetings included discussions around vision and strategy for the service.
- Staff were aware of the monthly newsletter named 'News@NLAG' and said part of its content focused on trust vision and strategy. For example, in the April 2014 edition, the trust looked to recruit 100 'care makers' to celebrate and recognise staff who embody the six Cs.
- A new nursing strategy had recently been launched with focus on quality, a harm-free environment and meeting people's needs.

Governance, risk management and quality measurement

- Joint governance meetings were held monthly and attended by senior nursing staff; topics covered included governance, risk management and quality measurement.
- ITU network meetings were held every two months and this provided opportunity to share information with senior staff from other ITUs and discuss risk and quality.
- There was a critical care delivery group which met every three months which also addressed issues around risk and quality measures.
- The unit contributed to ICNARC.
- The nurses we spoke with felt the ITU was well-led and senior staff were approachable. Nursing leadership on the HDU was not recognised as being as strong and this was partly because the band 7 nurse's time was split, including the role of matron and ITU shift manager.
- The team of band 5 nurses had no supportive structure including a mix of band 6 and 7 nurses involved in the clinical care on the HDU.
- Nursing staff on the ITU felt well supported and well informed; nursing clinical guidelines on the unit were up-to-date and care followed best-practice guidelines.
- Senior nursing staff were visible on the ITU and had a suitable understanding of the day-to-day running of the service.
- From a medical perspective, on the ITU, a sense of strong leadership was less apparent.
- The concerns highlighted in other sections of this report point to weaknesses with senior leadership and direction for the service. For example, the consultant working patterns, once daily ward rounds at weekends, lack of medical clinical guidelines on the ITU, concerns with some practice (i.e. high tidal volumes) and medical cover for the HDU was a concern.
- Other concerns were around the limited numbers of doctors available for support out of hours, patients not being seen at all times within 12 hours of admission by a consultant, no training for doctors transferring critically ill patients in an ambulance and out-of-hours critical care cover provided by medical staff not trained in intensive care.
- We spoke with the associate director for surgery and critical care and asked about any foreseeable changes to the service and key challenges ahead. There appeared to be no clear direction and there were no plans to alter the existing ways of working.
- The importance placed on ensuring nationally-recognised, best-practice medical guidance was followed was not high on the agenda; this was a concern.

Critical care

Culture within the service

- The nursing sister on the ITU felt morale in the unit was good and there was a good team that worked together well.
- The staff nurses on the HDU felt abandoned at times when senior nurses had left the department. They reported that the ward 'ran itself'. The staff nurses felt they were not being listened to about the potential changes to their shift patterns.
- We were informed that short-term staff sickness levels were comparatively low, staff retention was good and about two-thirds of staff had worked on the unit for over 10 years.

Public and staff engagement

- For the ITU, patient surveys have been used in the past to engage with patients and get their views on the care they received. However, these were done over three years ago.
- All patients on the ITU were invited to a critical care outreach follow-up clinic. Patients were invited to express their views about their experiences. Information from the meetings was recorded and emailed to the unit nursing sister.
- From a recent follow-up clinic, patients commented how handovers were noisy; staff have since been encouraged to be quieter.
- We observed a comments box in the relative's room; this was used to encourage people to provide their views about the service and ITU in general.
- The ITU nursing sister felt that staff built positive relationships with relatives and this was a key part of the service.
- Attempts were made to engage with staff including the NLAG staff and members newsletter.
- The unit nursing sister attempted to engage with staff where possible including at team meetings, one-to-one meetings and through more general day-to-day engagement.

Innovation, improvement and sustainability

- A practice development group was in place and met every three months; the group focused on developing practice particularly in terms of innovation and improvement.
- The unit nursing sister felt the unit was forward thinking, particularly in comparison to similar sized units at other trusts. They said the ITU has access to high-frequency oscillatory ventilation (HFOV).

Maternity and family planning

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

Information about the service

The maternity service at Diana Princess of Wales Hospital Grimsby provided antenatal, intrapartum and postnatal care to women. The unit delivered approximately 2,715 babies in 2012/2013.

We visited the antenatal and the Labour Delivery Recovery and Post Care wards (LDRP) and theatres. We spoke with 10 women and 20 staff including midwives, midwifery support workers, doctors, consultants and senior managers.

We observed care and treatment and looked at care records. We also reviewed the trust's performance data.

Summary of findings

There were effective arrangements in place for reporting patient/staff incidents and allegations of abuse which was in line with national guidance. Staff were aware of the process for reporting and there was learning from incidents. A national trigger tool and maternity dashboard was used to identify and report incidents specific to maternity care.

Figures showed midwifery staffing levels were below those nationally recommended. The service was aware of this shortfall in midwifery staffing and staffing and escalation protocols were followed to ensure staffing and skill mix levels were safe on each shift. Women told us they had received continuity of care and one-to-one support from a midwife during labour. Medical staffing was in line with national recommendations.

Maternity used national evidence-based guidelines to determine the care and treatment they provided. There was a multidisciplinary approach to care and treatment which involved a range of providers across health care systems to enable services to respond to the needs of women. The service participated in national and local audits.

Most women spoke positively about their treatment by clinical staff and the standard of care they received. Some women felt communication and 'being listened to' could be improved. Women said staff treated them with dignity and respect. Women said they felt involved in developing their birth plan and had received

Maternity and family planning

sufficient information to enable them to make choices about giving birth. All women booked into the unit had a named midwife. Patient confidentiality was maintained in verbal communication, during discussions and in written records.

The service was well-led and understood the views of patients about their care. Concerns and best practice were shared to improve the service. Staff were encouraged to drive service improvement.

Are maternity and family planning services safe?

Good

There were effective arrangements in place for reporting patient/staff incidents and allegations of abuse which was in line with national guidance. Staff were aware of the process for reporting and there was learning from incidents. A national trigger tool and maternity dashboard was used to identify and report incidents specific to maternity care.

Maternity services were clean and effective procedures were in place to monitor infection prevention and control. Adherence to trust infection control policies was evident in most areas.

Staffing levels were set and reviewed at ward and board levels using nationally-recognised tools and guidance. Figures showed midwifery staffing levels were below those nationally recommended. The service was aware of this shortfall in midwifery staffing and staffing and escalation protocols were followed to ensure staffing and skill mix levels were safe on each shift. Women told us they had received continuity of care and one to one support from a midwife during labour.

Medical staffing was in line with national recommendations for the number of babies delivered on the unit each year. There were adequate numbers of junior doctors on the wards and any gaps in the rota were filled by internal medical cover.

Care and treatment was planned and delivered in a way to ensure women's safety and welfare. Risk assessment tools were used to ensure appropriate referral of women developing critical illness during or after pregnancy.

Clinical records were completed to a good standard. Each record contained a clear pathway of care which described what women should expect at each stage of their labour. When not in use records were kept safe in line with data protection.

Incidents

- Maternity had no recent Never Events. Trust policies on reporting incidents were embedded. All staff we spoke with said they were encouraged to report incidents.

Maternity and family planning

- There had been two serious incidents reported trust-wide for maternity areas between December 2012 and March 2014, none of these were reported for this hospital.
- A national trigger tool and maternity dashboard was used to identify and report incidents specific to maternity care. There was a proactive and reactive response to incident management. Incidents were discussed at the clinical governance group each month. Records showed there was learning and actions had been taken where required. Individuals involved in serious incidents could request feedback from the governance teams. Some staff told us they sometimes had to chase a response and were not always able to attend lessons learnt sessions due to work pressures. A directorate learning lessons newsletter was available for staff regarding incidents.
- There was a good track record in unexpected admission to NICU, maternal unplanned admission to ITU, suspension of maternity services, unexpected neonatal death, intrapartum death and maternal deaths.
- Monthly perinatal mortality and morbidity meetings were held. All serious cases including stillbirths and neonatal deaths were reviewed as a peer group. A junior doctor told us there was protected time for learning. At trust level the doctor told us they had been invited to attend the mortality meeting by the Chief Executive.

Safety thermometer

- Maternity did not use the safety thermometer to monitor patient harms and 'harm free care'. The head of midwifery informed us information specific to maternity risks was being developed and would be in place in the next six weeks.
- Records we looked at evidenced risk assessments for venous thromboembolism (VTE) were carried out. An audit in October 2013 showed 100% of women had been assessed for VTE at booking, delivery and postnatally.

Cleanliness, infection control and hygiene

- The maternity unit was visibly clean. Staff reported they had received infection control training. Policies were adhered to in most clinical areas such as 'bare below the elbows' dress code and we saw staff regularly washed their hands. However, we observed some staff in antenatal clinic did not wear gloves or wash their hands when handling urine specimens. We discussed this with staff who said it was common practice not to wear gloves unless testing urine.
- Cleaning schedules were in place and there were clear processes for checking the cleanliness of the environment and decontamination of equipment.
- There were no cases of methicillin-resistant staphylococcus aureus (MRSA) bacterial infections or clostridium difficile infections detected in the last six months for maternity.

Environment and equipment

- The environment in the maternity unit was safe.
- Equipment was appropriately checked regularly. There was adequate equipment on the wards to ensure safe care (specifically cardio tocograph (CTG) and resuscitation equipment). Staff confirmed they had sufficient equipment to meet need.

Medicines

- Medicines were stored correctly and appropriate checks carried out. The labour delivery recovery post natal LDRP areas had medication stored in the same place on each ward which minimised medication risks.
- Fridge temperatures were checked in all clinical areas.

Records

- The completion of the World Health Organization (WHO) surgical checklist showed compliance in the sample of records we looked at. The service also used a surgical safety briefing checklist. This recorded women's weight, clinical observations, medical and obstetric concerns, equipment and staffing. Checklists were signed by the surgeon.
- Clinical records were completed to a good standard. Each record we looked at contained a clear pathway of care which described what women should expect at each stage of their labour. When not in use records were kept safe in line with data protection.
- Five sets of records were reviewed each month on an ongoing basis and action taken to improve the quality of record keeping. In March 2014 the service achieved compliance against level 2 national risk management standards achieving 10/10 for quality of record keeping.
- The child's health record (RED Book) was given to parents at their first antenatal visit by the health visitor who spent time with parents explaining the contents.

- 'Fresh eyes' approach was used, where two staff reviewed foetal heart tracings to reduce misinterpretation, improving patient safety.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. We observed an antenatal assessment with the women's consent. The woman was given choices about their care and the risks, benefits and alternative options were discussed. The consent process was supported by written information.

Safeguarding

- There were two safeguarding midwives for maternity services. Midwives in each of the areas also had link roles for safeguarding.
- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trusts' whistleblowing procedures and the action to take.

Mandatory training

- Records for April 2014 showed that 69% of staff in the maternity unit at Grimsby were up to date with their mandatory training. This was against a trust target to achieve 95% by the end of December 2014.
- Staff confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training. Staff had also attended annual multidisciplinary skills drills obstetric emergency study days.

Management of deteriorating patients

- The service used the Maternity Early Obstetric Warning Scoring System. There were clear directions for escalation and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.

Midwifery staffing

- Births to midwife ratio was 1:33 against a nationally recommended ratio of 1:28. The unit was using an acuity tool to ensure staffing levels and skill mix was safe.
- Ideal and actual staffing numbers were displayed on every ward. Staff reported that they were only rarely understaffed and vacancies were filled with internal bank staff. The unit did not use agency staff
- There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster. Staff reported good cross department working
- Women told us they had received continuity of care and one to one support from a midwife during labour. Trust data for 2012 showed the rate of women receiving one-to-one care in labour was 99.1%.
- We observed a handover which was attended by two consultants, junior doctors and two advanced midwifery practitioners. The LDRP coordinator led the handover. Gynaecology medical staff were also in attendance and gave handover after the obstetric report. The Situation, Background, Assessment, Recommendation (SBAR) communication tool was used. The tool is used in maternity where there may be multiple handovers between staff and it assists in improving communication. The handover included women's social and personal needs which evidenced a holistic approach to care.

Medical staffing

- Consultants were present on the labour ward for 60 hours a week. This was in line with national recommendations for the number of babies delivered on the unit per annum.
- There were adequate numbers of junior doctors on the wards and any gaps in the rota were filled by internal medical cover.
- The unit was not overly reliant on locum medical staff and where required only used locums which had previously worked in the unit.
- Anaesthetist – 24-hour cover.
- Maternity scored better than expected for junior doctor workloads (General Medical Council – National Training Scheme Survey 2013).

Major incident awareness and training

- The trust had a business continuity plan dated 12 November 2013 and an overarching business continuity policy dated 25 April 2014. Key functions were set out in the plan in order of priority and these included bed management and site management. The plan outlined

specific risks and a business impact analysis was included. Recovery time objectives (RTO) and maximum tolerable periods of disruption (MTPD) were not specified.
- Business continuity plans for maternity were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for Emergency Preparedness, Resilience and Response. A mix of training was available for key staff utilising emergency plans such as table top exercises and practical training.

Are maternity and family planning services effective?

Good

Maternity used national evidence-based guidelines to determine the care and treatment they provided. There was a multidisciplinary approach to care and treatment which involved a range of providers across health care systems to enable services to respond to the needs of women.

The service participated in national and local clinical audits. Records showed most recommendations from audits had been fully implemented.

Patient outcomes were monitored and reviewed. Data showed normal delivery rates were higher than that reported nationally, emergency caesarean section rates were significantly lower than expected and maternal and neonatal readmission rates were lower than expected. Where indicators were not within the expected range such as stillbirths there was evidence the service was taking action to improve in this area.

A process was in place to identify learning and development of staff. Staff told us they had received appraisals and there was a proactive approach to midwifery supervision. Midwives expressed a positive experience of supervision.

Evidence-based care and treatment

- Maternity used a combination of NICE (e.g. QS22, 32 and 37), and RCOG guidelines (e.g. Safer Childbirth: minimum standards for the organisation and delivery of care in labour) to determine the treatment they provided. Local policies were written in line with this and were updated three years or sooner if national guidance changed
- The directorate participated in a variety of local audits such as documentation, swab checks, third and fourth degree tears, stillbirth review and ante-natal steroids for pre-term labour. There was a clinical audit action plan for 2013/2014 which identified the date action was required, person responsible and evidence of completion. Records showed most recommendations had been fully implemented.

Pain relief

- Information was given to women to make them aware of the pain relief options available to them.
- Various pain relief was available for birthing women which also included drug-free methods.
- There was a 24-hour epidural service.

Nutrition and hydration

- Most women told us they had a choice of meals and these took account of their individual preferences. They told us the food was satisfactory and most women said they had received sufficient portion sizes.

Patient outcomes

- In the last 12 months there were 2,715 deliveries at this hospital.
- Normal delivery rates were higher than that reported nationally.
- The trust had lower rates of caesarean sections compared with nationally.
- Emergency caesarean section rates were significantly lower than expected.
- Maternal readmission rates were lower than expected.
- Neonatal readmission rates were lower than expected.
- There were five maternal admissions or transfers to ITU (March 2013–February 2014).
- There were 12 incident forms completed for unplanned admissions to Neonatal Intensive Care Unit (September 2103–February 2014)
- Based on 2011/12 data the service was an outlier for stillbirths. Records showed each stillbirth was investigated using the National Patient Safety Agency toolkit and if necessary an external supervisory

investigation. The head of midwifery told us there was an ongoing review of stillbirths working in partnership with other agencies such as public health on actions for smoking, obesity and breastfeeding.

- The service participated in the Royal College of Obstetricians and Gynaecologists 11 Maternity quality indicators. They had passed in three of the four data areas. Action had been taken to improve within this area and included audits for third and fourth degree tears and induction of labour. The directorate participated in all of the clinical audits it was eligible for.

Competent staff

- Newly qualified midwives undertook a preceptorship programme.
- There was a proactive approach to midwifery supervision. Midwives expressed a positive experience of supervision. Student midwives had a supervisor of midwives (SOMs) allocated to them. The ratio of supervisors to midwives was 1:18 against a recommended ratio of 1:15. Four student SOMs were about to undertake training.
- The service had ten Advanced Midwifery Practitioners (AMPs) in post who were trained to carry out advanced clinical procedures. The AMP's covered the unit 24 hours, seven days a week.
- The trust had a target of each directorate achieving 75% compliance for appraisal by the end of the year. Records showed that 69% of staff in maternity had received an appraisal. All staff we spoke with confirmed they had received an annual appraisal.
- Junior doctors attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors at any time if they had concerns.
- The service was rated as within expectations for two out of the three Antenatal and New-Born Screening Education Audit indicators. We discussed the requirement for a screening coordinator with the Head of Midwifery. They told us the post was previously funded by commissioners which had now ceased. However, the post had been appointed to and was being funded by the directorate until external funding was secured.

Multidisciplinary working

- Staff told us they received good support from the critical care outreach team to ensure safe transfers if women required intensive care.
- There were clear processes for multidisciplinary working in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postanally to another unit. This was achieved using the ACCEPT approach to ensure the right patient had to be taken at the right time by the right people to the right place by the right form of transport and received the right care throughout.
- For those women who had certain pre-existing medical conditions, such as diabetes or epilepsy, a joint clinic was available where a consultant obstetrician and physician were present to manage care.
- Communication was sent to the GP by email automatically on discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken.

Seven-day services

- There was sufficient medical cover out of hours. Consultants were present on the labour ward from 9am to 2pm at weekends with other hours on call from home.
- Seven-day working was operational in diagnostic services such as CT, MRI, Radiology and ultrasound.

Are maternity and family planning services caring?

Good

Most women spoke positively about their treatment by clinical staff and the standard of care they received. Some women felt communication and 'being listened to' could be improved. Women said staff treated them with dignity and respect. Women said they felt involved in developing their birth plan and had received sufficient information to enable them to make choices about giving birth. All women booked into the unit had a named midwife. Patient confidentiality was maintained in verbal communication, during discussions and in written records.

There were facilities to ensure women and their families were supported following bereavement. Access was

available to a named bereavement midwife. There were bereavement policies and procedures in place for supporting parents. Formal bereavement training for midwives was being arranged.

Compassionate care

- In the CQC Maternity Services Survey 2013, 119 responses (a response rate of 14.3%) were received from women about their care at this trust. The trust performed about the same as other trusts for labour and birth and better than other trusts for staff during labour and birth and care in hospital after birth.
- The friends and family test results for March 2014 (NHS Choices) showed that the majority of women were extremely likely or likely to recommend the service at Grimsby to their family or friends. Friends and family cards were given to women at discharge and boxes were available in clinical areas for comments to be submitted.
- Most women spoke positively about their treatment by clinical staff and the standard of care they had received. One woman told us she felt she hadn't been listened to and another woman felt there had been a breakdown in communication relating to pain relief, feeding, and discharge. We discussed this with the senior midwife following a review of the clinical notes. They acknowledged communication had not been as thorough as it should have been and addressed this immediately.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. There were arrangements in place to ensure privacy and dignity. Women said staff treated them with dignity and respect.

Patient understanding and involvement

- Women said they felt involved in developing their birth plan and had received sufficient information to enable them to make choices about giving birth.
- All women booked into the unit had a named midwife and their contact details. In addition, there was a 24-hour, seven-day-a-week 'hotline' for women to call if they had any concerns
- Women who chose to have their birth in hospital were offered a tour of the unit with their partner prior to the birth.
- Women had access to their hand held records throughout their pregnancy. Patient confidentiality was maintained in verbal communication, during discussions and in written records.

Emotional support

- There were facilities to ensure women and their families were supported following bereavement. There was a family room on the LDRP ward.
- Access was available to a named bereavement midwife.
- There were policies and procedures in place for supporting parents in cases of stillbirth or neonatal death this included referral to the Blue Butterfly group, which was facilitated by the chaplaincy and offered support to families following bereavement.
- Although staff provided caring and compassionate care to parents following pregnancy loss they told us they had not received any formal training in bereavement. Minutes from the April 2014 foetal loss meeting showed that supervisors of midwives were organising training sessions for later in the year.
- Research nurses were working with local women on a project to examine early motherhood depression.

Are maternity and family planning services responsive?

Good

The services worked with local commissioners of services, the local authority, other providers, GP's and patients to coordinate and integrate pathways of care that met the health needs of women. There was integrated working between the children's centres and midwifery team which had led to women accessing antenatal services earlier.

There were arrangements in place for access to the service and discharge or transfer of women which met their needs. Information was shared effectively with agencies, such as GPs, social services and community services.

The service responded to the needs of vulnerable patients. There were specialist midwives who provided support in areas such as teenage pregnancy and substance misuse. There was a team of peer support workers at the hospital and in the community who provided advice and support

for women who chose to breastfeed. A range of leaflets about care and treatment was available in different formats and languages. Access was available to interpreting services.

Complaints were handled in line with trust policy. Information was given to women about how to make a comment, compliment or complaint. There was learning from complaints and concerns and action and improvement to services was taken where required.

Service planning and delivery to meet the needs of local people

- The service was aware of the risks to the service such as staffing levels and skill mix, geography of the three trust sites and investment in community services. It worked with local commissioners of services, the local authority, other providers, GP's and patients to coordinate and integrate pathways of care that met the health needs of women. There was integrated working between the children's centres and midwifery team which had led to women accessing antenatal services earlier.

Access and flow

- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as required. The midwives were available on call 24 hours a day for advice.
- Grimsby offered a Labour, Delivery, Recovery and Postnatal (LDRP) care model facilitated by four multidisciplinary teams. Women were assigned to a particular team and received all their care within the LDRP area. The model provided good continuity of care although occasionally staff found there were bed pressures during busy times.
- Prior to discharge women were given a transfer home pack from the midwife and seen by the community midwifery team the day following discharge from hospital. Women were able to contact the ward up to 28 days post discharge if they had any concerns.
- There was good compliance in achieving six-hour discharges following delivery. AMPs and midwives were trained to perform examination of the newborn.
- The unit did not have to close 2012/13 due to over capacity.
- Bed occupancy was in line with the Royal College of Midwives recommendations.
- 73.40% of pregnant women accessing antenatal care were seen within 10 weeks compared with 19.80% seen within 20 weeks.

Meeting people's individual needs

- The service responded to the needs of vulnerable patients. There were specialist midwives who provided support in areas such as teenage pregnancy and substance misuse.
- There was a team of peer support workers at the hospital and in the community who provided advice and support for women who chose to breastfeed. The service had achieved level 1 UNICEF Baby Friendly Accreditation and was working towards level 2. This was a worldwide programme which encouraged maternity hospitals to support women with breastfeeding. While good work was ongoing with breastfeeding peer support workers, breastfeeding initiation and continuation rates were below the national average.
- A report from 2011 showed the trust was consistently above all the screening uptake targets and the failsafe visit in 2012 demonstrated good counselling and information given to women.
- A range of leaflets about care and treatment was available in different formats and languages. Access was available to interpreting services.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Information was given to women about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at ward level or through the trusts Patient Advice and Liaison Service.
- An Afterthoughts service was available for women and their partners if they had questions following birth. This involved a face-to-face appointment with the midwife.
- Learning from complaints and concerns was discussed at monthly staff meetings. Action taken following complaints included improvements to patient information leaflets and ensuring staff identified themselves and their position to patients when entering the consultation area

Are maternity and family planning services well-led?

Maternity and family planning

Good

Staff spoke positively about the service they provided for women. Quality and patient experience was seen as a priority and everyone's responsibility. Staff told us they were encouraged to raise concerns about patient care and this was acted on. Staff were dedicated and worked well as a team.

Staff were aware of their roles and responsibilities. Staff reported that leadership on the wards was good and they received the necessary support to undertake their role. Most staff told us senior managers were visible and known to them.

The service understood the views of patients about their care. Concerns and best practice were shared to improve the service. Staff were encouraged to drive service improvement.

Vision and strategy for this service

- The trust's vision and values which promoted compassion, dignity, respect and quality was visible in clinical areas. Staff had been provided with a pocket card which set out the trust's strategy.
- The service was in the process of organising staff engagement events to help inform the women's and children's vision and strategy. Key themes were organised around the five national domains contained in the NHS Outcomes Framework (December 2013).

Governance, risk management and quality measurement

- In March 2014 the trust achieved level 2 accreditation against national maternity clinical risk management standards achieving a score of 46/50.
- Monthly governance meetings were held where incidents, complaints, claims, audits and guidance were discussed. Staff were kept up to date with this information through newsletters, staff meetings and team briefings.
- A quality dashboard was completed. Most staff told us they were aware of the quality issues in the service. However the dashboard was not displayed in clinical areas.
- Risks were escalated to the trust risk register and monitored each month.

Leadership of service

- Staff were aware of their roles and responsibilities. Management structures showed clear lines of accountability.
- Staff reported that leadership on the wards was good and they received the necessary support to undertake their role.
- Openness and honesty was the expectation for the service and was encouraged at all levels.
- Most staff told us senior managers were visible and known to them.

Culture within the service

- Staff spoke positively about the service they provided for women. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff told us they were encouraged to raise concerns about patient care and this was acted on.
- Staff were dedicated and worked well as a team. There was good multidisciplinary working.
- Staff sickness levels were within expected numbers.
- Trust figures for January 2014 showed staff were reporting ongoing increases in staff engagement, morale and the ability to implement change at both ward/department and trust level. Staff told us morale in the unit was good.

Public and staff engagement

- The service took account of the views of women and their families through the Maternity Liaison Services Committee, a multidisciplinary forum where comments and experiences from women were used to improve standards of maternity care.
- Service user representatives were invited to the labour ward forum and patient information group.
- The service had a 'You Said We Did' communication board. This showed action had been taken in response to patient feedback. Improvements had been made to the quality of food environment and communication.

Innovation, improvement and sustainability

- Obstetric theatres were supported by a team of health care assistants who had undertaken the necessary training to become 'scrub nurses'. The service was provided on a 24/7 rota. The role eliminated the need for midwives to scrub for theatre enabling them to support women in labour.
- The service were finalists 2014 Royal College of Midwives award for 'supervisors of midwives team'.

Services for children and young people

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

Information about the service

Within the hospital there are 16 paediatric beds and two high dependency beds. All inpatient paediatric beds are located on Rainforest ward. The ward admits children from birth . Young people are admitted up to the age of 16 years old and there were formal arrangements in place to treat and care for young people up to the age of 19 years old where required. In addition, there are four assessment beds located within the Accident & Emergency (A&E) department. The ward provided a range of paediatric services including general surgery, medicine and high dependency care. The hospital also has 12 neonatal intensive care (NICU) beds. There was also an outpatient clinic service. Between April 2013 and March 2014, the children's service had 4,482 admissions.

We visited Rainforest ward, NICU, the Accident & Emergency (A&E) department and the outpatient area. We spoke with 15 patients or relatives and 23 members of staff including consultants, registrars, junior doctors, the Head of Children's Services, the matron, ward managers, staff nurses, health care assistants, ward clerks and domestic staff.

Summary of findings

Children's services are generally safe. A paediatric early warning scoring system (PEWS) was used on Rainforest ward to identify a deteriorating child and there were adequate numbers of nursing and medical staff. Incidents were well reported and learned from. Children's services were effective as the hospital used evidence-based care and treatment and had a clinical audit programme in place.

Nursing, medical and other healthcare professionals were caring and children and parents were positive about their experiences. Parents felt involved in the decisions about their children's care and treatment and records were completed sensitively. The hospital were mostly meeting people's individual needs but access to information in other languages, such as leaflets for patients could be improved. The trust was improving the way it handled complaints.

Children's services were well-led. Staff were aware of the trust vision, although they were not aware of the specific vision for the children's services. There was a named senior registered nurse who was responsible for influencing the commissioning and management of children's services. Quality and patient experience was seen as all staff's responsibility.

Services for children and young people

Are services for children and young people safe?

Good

We found children's services safe. Appropriate paediatric early warning scoring system (PEWS) were in use on Rainforest ward to identify a deteriorating child and there were adequate numbers of nursing and medical staff. Incidents were well reported and learned from.

Incidents

- There have been no recent never events reported within children's services. There was one serious incident reported between 1 April 2013 and 3 April 2014 (ward areas).
- All staff we spoke to stated that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at ward meetings and staff were sent a quarterly newsletter to share lessons learned.
- Staff were aware of what incidents and errors to report and how a report should be made.

Safety thermometer

- The hospital has an adult safety thermometer but children's services found it largely irrelevant.

Cleanliness, infection control and hygiene

- Ward areas appeared clean and we saw staff regularly wash their hands and use hand gel between patients.
- Bare below the elbow policies were adhered to.
- Patients were screened on admission for MRSA.
- If patients were found to have either C. difficile or MRSA they were isolated in a side room.
- We found that infection control audits such as MRSA screening and hand hygiene were carried out on a regular basis.
- We found no information on infections and hand hygiene audits displayed on NICU or Rainforest ward.
- Rainforest ward had dedicated cleaning staff who had responsibility for ensuring the ward was clean.
- Nursing staff on NICU cleaned equipment and damp dusted the surfaces in clinical areas. The domestic staff had responsibility for cleaning floors, bathrooms and toilets.

Environment and equipment

- The environment in the children's department was safe.
- Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the wards to ensure safe care.
- Play areas inspected were found to be clean and toys and games were found to be age appropriate for children.
- There was a dedicated room for young people to use and activity equipment such as a computer.
- Toys and games were provided in outpatients.

Medicines

- Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- Nurses prepared intravenous drugs and infusions within ward treatment room areas and there were arrangements in place for pharmacy to make these up if required.
- We found that children and babies were weighed and their weights recorded on drug administration charts.
- There were standards in place for checking drugs before administration and staff told us where they find information on medicines.

Records

- All records were in paper format on NICU and all health care professionals documented in the same place.
- There were no care plans in place on NICU. We were informed the trust was changing over to an electronic patient record system that would encompass care plans for each baby. We raised the issue of there being no care plans in place with senior staff.
- Rainforest ward had care plans in place.
- We saw appropriate risk assessments were completed within NICU.
- The trust informed us that routine nutritional screening and tissue viability assessments were carried out on Rainforest Ward. However, we saw no evidence of this in the children's care files we examined.

Consent

- Patients were consented appropriately and correctly. We were told that staff received mandatory training on the Mental Capacity Act every three years. The most recent audit showed that the children's ward had

achieved 61% compliance on nursing staff attending Mental Capacity Act training (with 13 staff not meeting the requirement) and 69% compliance for medical staff (with nine staff not meeting the requirement).
- We saw consent forms that included spaces for the signature of the parent and young person. Parents told us they were fully informed and felt involved.
- We did not see any documentation to assess a child/ young person's ability to make a decision, although the trust informed that these took place. Within the trust the Adult Protection team assisted young people and those who have a learning disability to make informed decisions.

Safeguarding

- The hospital had a named doctor for safeguarding who provided one session a week. All NHS trusts are required to have a named doctor for safeguarding who provide advice and expertise for fellow professionals and promote good practice within their organisation in line with the Safeguarding Children and Young People; roles and competencies document (RCPCH, 2010).
- In addition there was a separate designated doctor for safeguarding.
- The hospital had a named nurse for safeguarding who worked full time.
- There was an executive lead for safeguarding within the trust.
- A safeguarding team was in place. The team provided safeguarding supervision sessions four times a year to ward-based staff.
- A paediatric liaison nurse was in post. Their role was to investigate all admissions and identify any child in need and in addition, screen for any safeguarding matter. The liaison nurse liaised with the multidisciplinary team and ward-based staff.
- A coloured sheet was used in patient records to identify and highlight to staff that the child was classed or had been classed as a child in need. These coloured sheets remained as permanent addition to the notes to highlight to staff to be extra vigilant.
- There was a written safeguarding children policy and procedure in place.
- We found staff knew how to respond appropriately when there were concerns about a child or young person.

Mandatory training

- We looked at the staff mandatory training audits.
- Records confirmed that 75% of staff on the paediatric wards were up to date with their mandatory training and 79% of medical staff were up to date.
- Medical staff had received safeguarding training at level 1, 2 or 3. 100% of staff had received level 1 training, 100% level 2 training and 100% had received level 3 training.
- Ward staff had received safeguarding training at level 1, 2 or 3. 94% of staff had received level 1 training, 94% level 2 training and 94% had received level 3 training.
- Staff received annual resuscitation training. 100% of medical staff had received an annual update with all staff meeting the requirement. 75% of staff on the wards had received their annual update with 13 staff not meeting the requirement. We spoke to staff who told us they were paediatric intermediate and advanced life support trained.

Management of deteriorating patients

- Rainforest ward used the Paediatric Early Warning Scoring System (PEWS). There were clear directions for escalation printed on the reverse of the observation charts and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that repeat observations were taken within the necessary time frames.

Nursing staffing

- NICU Nursing staffing numbers were assessed using the British Association of Perinatal Medicine (BAPM) acuity tool. Ideal and actual staffing numbers were not displayed on NICU.
- There was a children's services establishment review. The review had an aim of ensuring the nurse/patient ratio meets the Royal College of Nursing (RCN) standard of one nurse to five patients per shift. In addition, there was a recommendation in the review for one nurse on every shift to be a band 6 grade.
- We were informed the ward employed a registered general nurse (adult) who on occasion took charge. The trust should consider the National Children's Service Framework (England) (DH, 2003a), and the findings of the Kennedy report (2001) that clarified that children and young people should always be cared for by health

care professionals who hold a recognised qualification in caring for children. The trust informed us that support was available from sick children's nurses on these occasions.
- There was no recognised acuity tool used to determine dependency on Rainforest ward.
- Rainforest ward displayed ideal and actual staffing numbers based on current establishment figures.
- Nursing handovers occurred twice a day at 7am and 7.30pm. We read nursing records and asked the nursing staff about particular care needs. We found nurses to be knowledgeable about each child's needs.

Medical staffing

- There was consultant cover on NICU and Rainforest ward from 9am to 5pm Monday-Friday. After 5pm and at weekends consultants were called out via an on-call rota. All children were seen by a consultant within 24 hours of admission to the ward.
- There were guidelines in place that state a consultant neonatologist would be called in immediately when a baby is born under 31 weeks.
- The junior doctor rota had vacancies at tier 1 level. This gap was filled by locums. There were no gaps at middle grade or specialist registrar level. All children were seen by a doctor on the middle grade rota within four hours.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours and that consultants had a very low threshold to come back onto the ward to review their patients.
- We observed a medical handover and found evidence of appropriate investigation and treatment against national guidance such as the National Institute of Clinical Excellence (NICE).
- There were consultant-led handovers Monday to Friday. The handover was observed was structured, documented and attendance was recorded.
- We spoke with surgeons who told us they complied with their Royal College guidelines regarding the treatment of children. This was confirmed by the matron.

Major incident awareness and training

- The trust had a major incident plan dated 21 March 2014. There was a Resilience Manager in post and an emergency preparedness steering group. Within the plan there was a set of action cards for staff to follow that included action to be taken in the event of a paediatric arrest. A Command and Control structure was also outlined in the plan.
- The trust had a business continuity plan dated 12 November 2013 and an overarching business continuity policy dated 25 April 2014. Key functions were set out in the plan in order of priority and these included bed management and site management. The plan outlined specific risks and a business impact analysis (BIA) was included. Recovery time objectives (RTO) and maximum tolerable periods of disruption (MTPD) were not specified.

Are services for children and young people effective?

Good

We found the children's services were effective as the hospital used evidence-based care and treatment and had a clinical audit programme in place. There was evidence of multidisciplinary working and access to seven-day services. Children received care and treatment from competent staff. Effective pain relief arrangements were in place.

Evidence-based care and treatment

- The children's service used a combination of NICE, Royal College of Paediatrics and Child Health (RCPCH) guidelines to determine the treatment they provided. Local policies were written in line with this and were updated if national guidance changed.
- We observed evidence-based care being discussed at the medical handover.
- At the monthly departmental meetings any changes to guidance and the impact that it would have on practice was discussed.

Pain relief

- Children receive appropriate pain relief and the pain team are available if required.
- We found a range of distraction techniques were used before a procedure was performed.

Nutrition and hydration

- Drinks, snacks and an appropriate choice of food were available for children and young people.
- Multi-faith foods were available on request.
- There were facilities for the management of bottle-feeding.

Services for children and young people

Patient outcomes

- Children's' services had an audit programme and participated in national audits including the paediatric asthma, fever and pneumonia audits and the paediatric intensive care audit (PICANet).
- There was no evidence of risk regarding in-hospital mortality for paediatric and congenital disorders (Paediatric and Congenital Disorders and Perinatal Mortality, 1 April 2012 to 29 January 2014).
- There was no evidence of risk regarding re-admission rates in the neonatal unit.

Competent staff

- The trust began to collate data from July 2013 on how many staff had received an appraisal. The data related to the women's and children's service and not just the children's service. 69% of staff had received an appraisal with and overall trust compliance of 75%.

Multidisciplinary working

- The ward had access to physiotherapists and occupational therapists; they did not generally attend the morning ward round.
- In addition there was a dedicated pharmacist for the children's service.
- We saw young people over the age of 16 years being cared for within the service and saw evidence that their transition into the adult services was being effectively managed.
- Children and young people who were in need of psychiatric or psychological treatment and support had access to specialist input.

Seven-day services

- Nursing cover was the same seven days a week. Medical cover changed out of hours.
- Patients had access to physiotherapists and occupational therapists.
- Radiology ran at the weekends and bank holidays.
- An out of hour's pharmacist was on call and staff had access to ward stock drugs.

Are services for children and young people caring?

Good

Nursing, medical and other healthcare professionals were caring and children and parents were positive about their experiences. Parents felt involved in the decisions about their children's care and treatment and records were completed sensitively.

Compassionate care

- Throughout our inspection we witnessed children and their parents being treated with compassion, dignity and respect. We saw that children and young people were attended to promptly. The young people we spoke to told us, 'It's nice here'. Parents told us they were happy with the care.
- We looked at patient records and found they were completed sensitively and detailed discussions that had been had with children and their parents.
- Parents were encouraged to visit and open visiting times were in place for close family members.

Patient understanding and involvement

- Children and parents we spoke with felt that they had been involved in their care and decisions around their treatment.
- Each child had a named nurse and consultant.

Are services for children and young people responsive?

Good

We found services were responsive. Service planning, delivery to meet the needs of local people and access and flow arrangements were in place. The hospital were mostly meeting people's individual needs but access to information in other languages, such as leaflets for patients could be improved. The trust was improving the way it handled complaints.

Services for children and young people

Service planning and delivery to meet the needs of local people

- The hospital had a dedicated assessment unit located in the A&E department. The assessment unit ensured that children and young people were assessed appropriately before being admitted to a ward.
- The hospital children's service had plans to expand their community team. The aim of this expansion is to nurse more children in their own homes and therefore reduce hospital admissions further. The matron told us that children with conditions such as epilepsy and respiratory conditions would benefit from this service.
- The named senior nurse for children's' services met regularly with the North East Clinical Commissioning Group (CCG). We read the minutes dated 11th September 2013 and noted the CCG were seeking approval/agreement to the enhancement of the children's community service.
- Matrons and ward managers are responsible for bed management and regularly liaise with the bed management team.
- Arrangements were in place for four surgical and one medical planned admissions per day (Rainforest ward). These admissions were checked for changes by the ward staff the day before. Any changes to the planned admissions had to be authorised by the ward manager.

Access and flow

- Children were referred to the paediatric ward through the A&E department, the assessment unit or a GP. Children who required a period of assessment were looked after in the assessment unit, which had four beds, located next to the A&E department. This meant that children were not kept in A&E for a lengthy period of time. The assessment unit was not open overnight. A registered paediatric nurse and a paediatric doctor staffed it. Children were either directly discharged from the assessment unit or admitted to the ward where required. Since the assessment unit had opened in December 2012, there had been a stepped change in admissions to the ward and an overall reduction.
- Babies born over 27 weeks gestation were transferred from the maternity unit to NICU.
- The trust is part of the North Trent Neonatal network. Embrace provides 24-hours, seven–days-a-week, critical care transport and clinical advice using conference-call facilities to liaise with sub-specialists. When necessary, an intensive care team skilled in the transport of critically ill children and infants will be mobilized.
- There were good arrangements in place for discharge and we saw evidence of discharge planning and individualised care packages for children.
- A discharge summary is sent to the GP on discharge from the service. This detailed the reason for admission and any investigation results and treatment undertaken.

Meeting people's individual needs

- Support was available for patients with learning disabilities or physical needs via a multi-agency approach. There was a lead paediatrician for learning disabilities but no senior nurse.
- A translation telephone service was available 24/7 and interpreters could be booked in advance for face-to-face consultations.
- There were information leaflets available for making a complaint. We only saw English language leaflets and information displayed in ward areas.
- There was no dedicated teacher or formal education arrangements. Staff told us that they contacted the patient's teachers to request school work if required.

Learning from complaints and concerns

- If a patient or relative wanted to make an informal complaint then they would speak to the ward sister or senior staff nurse. If they were not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the service.
- The Quality and Patient Experience Committee had reviewed the trust's management of complaints. We read a report on the trust's complaints action plan dated February 2014. We saw there were actions outlined, a dedicated lead for the action, a timescale to achieve the action and the progress outlined. Learning was shared through patient stories, which were a regular feature on the agenda of the committee and trust board.
- Ward staff said they discussed individual complaints at ward meetings and we saw the ward meeting minutes that confirmed this.

Services for children and young people

Are services for children and young people well-led?

Good

We found the children's service well led. Staff were aware of the trust vision although there was no specific vision for the children's service. There was a named senior registered nurse who was responsible for influencing the commissioning and management of children's services. Quality and patient experience was seen as all staff's responsibility.

Vision and strategy for this service

- The trust vision was visible throughout the wards and corridors. In addition, it was displayed on the six C's (Care, Communication, Competence, Courage, Compassion, Commitment) board located at the entrance of each ward.
- Staff were able to repeat the vision to us at focus groups and during individual conversations.
- There was no specific vision or strategy for the children's service.

Governance, risk management and quality measurement

- Children's joint clinical governance meetings were held within the directorate. These were chaired by the Head of Children's Nursing and attendees included Consultants, Matron's, Ward Managers, other specialty doctors, the Safeguarding Named Nurse and business managers. Complaints, incidents, audits and quality improvement projects were discussed.
- We read ward meeting minutes that confirmed that complaints, incidents, audits and quality improvement projects were discussed.

Leadership of service

- There was a defined leadership structure in place.
- There was a named senior registered nurse within the hospital who was responsible for influencing the commissioning and management of children's services. A senior nurse is defined by the RCN and the named nurse will fully meet the RCN standard when she completes her Masters degree.
- There was a nominated director with responsibility for ensuring that children and young people are given due consideration at board level.
- Staff told us there were regular 'walk rounds' by the Matron.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as everyone's responsibility.
- Staff spoke of how they were encouraged to speak up if they saw something they were unhappy with regarding patient care.
- Staff worked well together and there was obvious respect between not only the specialities but across disciplines.
- Service level staff survey data was available. The trust was rated better than expected or tending towards better than expected for eight of the 28 NHS 2013 staff survey key findings.

Public and staff engagement

- A women and children's group newsletter was disseminated quarterly so that all levels of staff were informed about successes, mandatory training issues, compliments, learning lessons, incidents and guidelines.
- The trust was rated better than expected or tending towards better than expected for eight of the 28 NHS 2013 staff survey key findings.
- The trust was seen as performing generally above the England average the inpatient and A&E test. The trust has a significantly lower response rate than the England average in both surveys.

Innovation, improvement and sustainability

- Nursing staff told us they were encouraged to look at their own learning and could access study days.
- Health care Assistants had accessed paediatric CARMA courses that aimed to develop confidence in recognising and assessing potentially sick patients. This course supported their knowledge and skills competences framework.

End of life care

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

Information about the service

End of life care services were provided throughout the trust. The Specialist Palliative Care (SPC) Team was located at Diana Princess of Wales Hospital. The team comprised of one part-time Band 7 Macmillian/End of Life Clinical Coordinator supported by a six-hour Band 3 Administration post. The service was provided Monday to Friday. It provided support and advice to inpatient services within the hospital.

We spoke with fourteen staff, reviewed 15 DNACPR information and 15 patient records. We did not speak with any patients.

Summary of findings

There was a Specialist Palliative Care (SPC) Team located at Diana Princess of Wales Hospital. It provided support and advice to inpatient services within the hospital. Staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients.

There was a clear strategy for End of Life Care and the risk to achieving good end of Life care was understood. Nursing staff prioritised safe, high-quality, compassionate care for patients at the end of life.

End of life care

Are end of life care services safe?

Good

EOLC care provided at the hospital was safe. DNA CPR forms were completed by appropriately senior clinicians and the trust had a process in place to identify the learning needs of staff.

Incidents

- Staff did not recall any incidents they had reported with reference to end of life care issues.
- Between December 2012 and March 2014 the trust had no reported serious incidents in this area.
- Staff told us they would complete an incident report if they were not able to provide a side room for a patient receiving end of life care.

Cleanliness, infection control and hygiene

- We saw good practice with hand hygiene from staff, when caring for patients. Staff followed the hospital policies on the prevention of infection and control.
- We observed the facilities available following death in the hospital. There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.

Environment and equipment

- Deceased patient's property was stored in the cashier office which was locked at night but during the day was unlocked so patient belongings were not kept confidential in the bereavement office.
- There were syringe drivers for people needing continuous pain relief. There was a process to ensure that they were available to patients 24 hours a day, seven days a week.
- We checked the resuscitation equipment on all of the wards we inspected and they were clean and all equipment was in date.

Records

- We reviewed 10 do not attempt cardio pulmonary resuscitation (DNACPR) forms.
- We saw that the forms had been signed appropriately by a senior member of staff.
- The trust had a palliative care handover document for use by staff. When a patient was identified as being at End of Life the handover information allowed staff to monitor the patient more effectively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw there were systems in place to review the needs of a patient with fluctuating capacity to consent in response to their changing needs.
- In April 2014, trust wide 72% of all staff with 68% of all staff at Diana Princess of Wales Hospital were compliant with MCA training.
- Trust wide 75% of nursing and midwifery staff and 55% of medical and dental staff were compliant with MCA training.

Safeguarding

- The trust had polices for safeguarding children and vulnerable adults. Staff were aware of the policies and procedures.
- Staff had an understanding of how to protect patients from abuse.

Mandatory training

- The palliative care team had produced an education and training programme to deliver all aspects of palliative and end of life care training.
- End of life training was not seen as mandatory training by the trust.
- The trust provided breaking bad news workshops and handbook for staff.
- We spoke with a link nurse who was very positive about their role in educating the ward staff.
- Junior doctors completed training for patients at end of life as part of their induction to the hospital.
- Trust Grade Doctors completed one day training in palliative care and end of life care. Trust grade doctors are experienced doctors but are not part of the national training scheme.
- The trust provided a multi-professional communications workshop in February/March 2014.
- The trust provided syringe driver training for registered nurses.
- Workshops on Palliative Care / End of Life Care Training for all staff were provided by the trust.
- In April 2014, 67% of staff were compliant with DNACPR training at Diana Princess of Wales Hospital.

End of life care

- 545 staff at Diana Princess of Wales Hospital had completed End of Life training in April 2014.

Nursing staffing

- There was End of Life Care Coordinator across the trust.
- There was an End of Life Link Nurse for oncology and one part-time Specialist Palliative Care Nurse at the hospital.
- There was a Quality Matron who took the lead for End of Life across the trust.
- Trust wide 72% of nursing and midwifery staff were compliant with DNACPR training.

Medical staffing

- Trust wide 56% of medical and dental staff were compliant with DNACPR training.
- Senior consultants on duty at week-end and bank holiday were available for delivering bad news.
- Staff told us there was lack of medical support and supervision for End of life care.

Chaplaincy staff

- The trust had 1.5 chaplaincy staff across all sites.
- There was a part-time chaplain based at the Diana Princess of Wales Hospital
- There was no chaplaincy cover for the trust on Fridays.
- The chaplaincy service had on call cover across the trust.
- The trust had recently recruited a full time chaplain who was commencing in post in May 2014.

Major incident awareness and training

- The trust had a business continuity plan dated 12 November 2013 and an overarching business continuity policy dated 25 April 2014.
- Key functions were set out in the plan in order of priority and these included bed management and site management.
- The plan outlined specific risks and a business impact analysis was included. Recovery time objectives (RTO) and maximum tolerable periods of disruption (MTPD) were not specified

Are end of life care services effective?

Good

Overall care and treatment was delivered in line with current legislation standards and recognised evidence-based guidance with the exception of DNACPR. The trust was working to improve its mortality indicators. There was a multidisciplinary approach to care and treatment.

Evidence-based care and treatment

- The National Institute for Health and Care Excellence (NICE) was rewriting guidance to remove reference to the Liverpool Care Pathway (LCP) following a recent independent review of the pathway. Senior clinicians and nurses were aware of this change.
- The palliative care staff based the care they provided on the NICE Quality Standard 13 – End of Life Care for Adults.
- The trust reviewed the NICE supportive and Palliative care guidance through the Palliative Care and End of Life Strategy Group
- The trust had developed a pathway for patients who were at the end of life.
- The trust provided a copy of Care Of The Dying Patient And Last Offices Policy (Adults). However, it was not dated or ratified by the board.
- The hospital contributed to the National Care of the Dying audit. The results from the audit were not available at the time of the inspection.
- The trust had a resuscitation policy "Decisions Relating to Cardiopulmonary Resuscitation Policy", published in June 2006 and later revised in December 2012. The trust completed a local audit for the completion of DNACPR in 2013/2014 to measure the Trust's current practice against their resuscitation policy.
- The trust was completing a trust-wide Audit of: End of Life Care including patients on the Liverpool Care Pathway which was due to be completed in May 2014. The results of this were not yet available.

Pain relief

- Anticipatory end of life care medication was prescribed appropriately. We reviewed medication administration records in a number of areas we visited and saw appropriate prescribing.
- Medical staff we spoke with said they followed the trust's clinical guidelines on anticipatory medication prescribing. We were shown this policy and it was dated October 2013.
- Some nursing staff said they needed at times to prompt doctors to prescribe anticipatory medicines. However, most said that this was managed well to avoid delays for patients and ensure good symptom management.

End of life care

- Appropriate syringe drivers were available to deliver sub-cutaneous medication. Staff said there was a pool of medical devices available and they could obtain a syringe driver within 20 minutes of it being prescribed. This included those who were being discharged home. We were told that the keys to operate the syringe drivers were the same whether in the community or in hospital making administration of medicines more prompt and timely.
- Access to Anticipatory Drugs was available 24 hours per day.

Nutrition and hydration

- Nutrition and hydration was included in new End of Life care plan. The end of life team had a clear end of life care plan, which was to be used across all sites and wards.
- This indicated that the aim should be for people to eat and drink normally for as long as possible, acknowledging that the need for hydration and nutrition may reduce as people approached the end of their life.

Patient outcomes

- The trust completed National care of the dying audit. The audit showed good documentation and use of stickers to identify patients who were at End of Life.
- The trust completed a national deceased patient audit but they were still awaiting the results.
- The trust completed a CQUIN for End of Life which included prescribed anticipatory drugs.

Competent staff

- The chaplain staff demonstrated a caring and compassionate approach towards patients, relatives and staff who may be distressed.
- Bereavement office staff said they were proud of the service they delivered; comforting patients and making sure people left confident and knowledgeable about what to do next after a death. However, the bereavement staff had not received any formal training in dealing with bereaved relatives.
- The chaplain staff and bereavement staff did not have formal clinical supervision. Bereavement staff were part of the finance department and did have access to support from the palliative care team.
- Nursing staff were friendly, and professional.

Seven-day services

- There was no chaplaincy cover on Fridays across the trust. The hospital contacts local organisations to provide cover if required.
- Complimentary therapies were available which were volunteer-led and not part of the core service.

Are end of life care services caring?

Good

Patients were made to feel safe and comfortable. Staff working in the service were caring, experienced, knowledgeable and passionate about providing good care outcomes for patients.

Compassionate care

- Staff told us that side rooms were usually provided for people who were at the end of their lives. However, we were told two incidents where some patients were cared for in four and six bedded bays because a side room was not available.
- Staff we spoke with demonstrated commitment and compassion to enabling good end of life care and dignified after death care.
- The trust took part in an Inpatient Survey between September 2013 and January 2014. Patients scored the trust 6.7 out of 10 for being involved in decisions about their discharge from hospital, if they wanted to be.
- The Humber Primary Care Trust (PCT) Cluster can be seen to be performing in the bottom 20% of all PCT clusters nationally. North East Lincolnshire and Goole formed part of the Humber PCT cluster.
- The cluster was in the bottom 20% for the categories “Patient Had Enough Choice About Where They Died”; “Enough Help with Nursing Needs”; “Staff Dealt with Family Sensitively After Patient Died”.

Patient understanding and involvement

- The trust took part in an Inpatient Survey between September 2013 and January 2014.
- Patients scored the trust 7 out of 10 for being involved as much as they wanted to be in decisions about their care and treatment.
- Patients scored 5.1 out of 10 for having someone on the hospital staff to talk to about any worries and fears.

End of life care

Emotional support

- The trust took part in an Inpatient Survey between September 2013 and January 2014. Patients scored the trust 6.6 out of 10 for receiving enough emotional support, from hospital staff, if needed.
- The trust provided chaplaincy support for patients across the trust.
- The chaplaincy service had local links with Roman Catholic Churches to provide Roman Catholic patients with support.
- The hospital had a multi-faith room with washing facilities.
- The trust had bereavement booklets to provide consistent up-to-date information in relation to accessing support and what to do after a death. The booklet for the Diana Princess of Wales Hospital had been updated.
- There was one Band 7 clinical nurse specialist at the Diana Princess of Wales Hospital.
- The maternity unit had bereavement midwives who provided support to parents whose babies had died, or who had had a miscarriage, neonatal death or termination for abnormality. The bereavement midwives helped parents to preserve memories and they provided emotional support during the next pregnancy.
- The hospital ran a "Blue Butterfly Group", that provided pregnancy loss bereavement support to patients.

Are end of life care services responsive?

Good

The hospital engages and works with local commissioners of services, the local authority and other providers to coordinate care and facilitates access to appropriate services.

Service planning and delivery to meet the needs of local people

- The bereavement office had procedures in place to try to ensure timely issue of death certificates. However, they said the only complaints they ever received were about delays in this due to waiting for medical staff to complete the death certificates when they were busy on the wards and unable to come down to the mortuary. They said they fed this back to staff teams to try and improve matters and make sure they had more time to spend with families rather than 'chasing up' medical staff.
- Rooms were available on site for relatives of patients at the end of their lives. Pull-out beds were also available if relatives wished to stay in the room with their loved one.
- The trust had a monthly EOL Strategy Group to discuss service planning and delivery, audits and action plans and training.

Access and flow

- We spoke with the specialist palliative and End of Life teams and they told us of their commitment to ensure patients' symptoms could be stabilised and patients could be discharged quickly to ensure that they were able to end their life in a place they had identified in their end of life plan.
- End of life discharge planning documentation supported the rapid discharge of patients who wanted to end their lives in their own home.
- Staff we spoke with reported excellent relationships and liaison with other agencies, such as the ambulance service, adult social care services in the community, district nurses and Macmillan nurses.

Meeting people's individual needs

- Interpreters were available when necessary. However, information leaflets from the bereavement office on what to do after a death were not available in any alternative languages or formats. Staff said they may ask the interpreters to translate information if needed.
- Staff had access to a language line for interpretation services.
- For patients in NE Lincolnshire, only 23% out of 80% of people who wish to die at home do so (End of Life Strategy Group Meeting February 2014).
- The service was monitoring monthly the preferred place of care and the reasons for non-achievement for patients. Monitoring commenced in February 2014.
- The percentage of patients dying on LCP recorded on the LCP audit tool at Princess of Wales Hospital has reduced from 42.9% in July 2013 to 0% in January 2014 (QPEC EOL Update Report March 2014).
- Arrangements had been made with the mortuary and local coroners to ensure where necessary, for religious and cultural reasons, bodies could be released promptly.

End of life care

Facilities

- There was a range of viewing rooms and a chapel of rest to enable relatives to spend time with their deceased loved one. Appropriate facilities are provided for viewing the deceased
- The Bereavement office was situated within the finance office and there was not a separate area for staff to take a distressed relative collecting personal belongings and paperwork. The trust were to review the designated spaces available for relatives to have private space for discussions and look to reinstate the relatives rooms on C Floor. (Integrated EOL Care Action Plan March 2014).
- Personal belongings were stored in the cashier's office in a plastic carrier bag and stored under the desks in the office. Valuable possessions such as money and jewellery were stored in the cashier's safe until collection.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they would speak to the person in charge of the ward who would try and resolve the issue. If it could not be resolved they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets and posters which were available on all wards.
- The service has an action plan which includes reviewing complaints and concerns from relatives about end of life care.
- The service reviewed three complaints included in the Quality and Patient Experience Committee Quarter three report.

Are end of life care services well-led?

Good

There is a clear strategy for End of Life Care and the risk to achieving good end of life care is understood. Nursing staff prioritise safe high-quality, compassionate care for patients at the end of life.

Vision and strategy for this service

- The trust had an End of Life Strategy and this was monitored through the End of Life Strategy Group.

Governance, risk management and quality measurement

- Governance meetings were held within the service and all staff were encouraged to attend including junior staff and administrative staff.
- Complaints, incidents and audits and quality improvement projects were discussed.

Leadership of service

- The trust had a board director who has the responsibility for End of Life Care.
- The trust had a Lead cancer nurse who worked across all sites.
- Staff had some access to a community based consultant in the Care Plus Group.

Culture within the service

- A palliative care link nurse spoke with pride about the work they were undertaking regarding end of life care and ensuring rapid discharge for patients when they wanted home to be their preferred place of death.

Public and staff engagement

- The trust held quarterly Liverpool Care Pathway Link Nurse Champions Meetings. Agenda items included the current experience of link nurses, replacement of the LCP, Training and discussion of end of life issues and concerns.

Innovation, improvement and sustainability

- The Macmillan End of Life Care Coordinator and Specialist Palliative Care CNS's will be running a workshop on the Trust Best Practice day in May 2014.

Outpatients

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

Information about the service

Northern Lincolnshire and Goole NHS Foundation Trust provided a range of outpatient clinics. At Diana Princess of Wales Hospital 203,191 patients attended outpatient clinics between April 2013 to March 2014. The hospital had a dedicated outpatient department (OPD) with dedicated staff.

We visited outpatient clinics for orthopaedics, ophthalmology and ENT. We also visited the Macmillan Unit for oncology patients.

We spoke with eight patients and carers, six staff and looked at four sets of patient notes. We looked at the patient environment, the availability of equipment, cleanliness and we looked at information provided to patients.

Summary of findings

Outpatient areas were appropriately maintained and fit for purpose. Incidents were investigated appropriately and actions were taken following incidents to ensure that lessons were learnt and improvements shared across the departments. The infection control procedures were adhered to in the clinical areas, which appeared clean and reviewed regularly. Staffing levels were adequate to meet patient need.

Patients received appointments within 18 weeks of referral. Patients told us staff were caring and explained their treatment to them.

The outpatient department understood the different needs of the communities it serves. The hospital monitored who used the service and the outcomes of care for the different population groups. However, the hospital had not responded to waiting times and Did Not Attend (DNA) rates. The trust planned to implement a 'go live' system in September 2014. There were no plans in place to improve the patient experience. The trust had quite high levels of cancellation of outpatient appointments.

There were clear lines of leadership within the department and staff knew to whom to escalate concerns.

Outpatients

Are outpatients services safe?

Good

Patient outpatient areas were appropriately maintained and fit for purpose. Incidents were investigated appropriately and actions were taken following incidents to ensure that lessons were learnt and improvements shared across the departments. The infection control procedures were adhered to in the clinical areas, which appeared clean and reviewed regularly. Staffing levels were adequate to meet patient need.

Incidents

- Between December 2012 and March 2014 this hospital had reported one serious incident in this area, which was graded low risk.
- Staff stated that they were encouraged to report incidents and received direct feedback from their matron. Themes from incidents were discussed at meetings and staff were able to give us examples of where practice had changed as a result of incident reporting.
- Staff told us they learn from incidents across the trust. An example of this was a serious untoward incident had occurred in the Outpatient Department at Scunthorpe General Hospital regarding patient ID checking. An ID check process had been developed and implemented at Diana Princess of Wales Hospital and training was given to all new medical staff.

Cleanliness, infection control and hygiene

- We saw staff regularly wash their hands and use hand gel between patients.
- We saw that bare below the elbow policies were adhered to by staff.
- There were weekly cleaning audits within the department that showed the clinic was cleaned and any issues were identified and improvements to the cleaning schedule were implemented.
- The outpatient department completed infection control audits. The department scored 100% for hand hygiene audit. The outpatient department was fully compliant for infection control.

Environment and equipment

- We looked at equipment and found it was appropriately checked and cleaned regularly. There was adequate equipment available in all of the outpatient areas. Staff confirmed they had enough equipment.
- The outpatient department completed an Ophthalmology Environmental Audit and the children's toys were highlighted as needed to be cleaned every day. Actions were discussed at the outpatient team meeting on the 9 April 2014 and a sign off sheet has been produced and was now completed by staff.
- Resuscitation trolleys in outpatients were centrally located and checked regularly. Single-use items were sealed and in date and emergency equipment had been serviced.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. We found all fridge temperatures were checked in all clinic areas.
- On the oncology unit an electronic key system (CLIQ) for fridges and drug cupboards had been implemented. Electronic keys were registered to qualified staff. This allowed for keys to be tracked and audited to individual staff usage.
- Patients were counselled for new medication and written information was given.
- The trust participated in the national outpatient survey in 2011 and they scored 8.3 out of 10 for being told the reason for a change in medication in a way they could understand.

Records

- Staff told us it was very rare for them not to have the full set of patient's notes for clinic appointments. However, during the inspection we observed a patient's notes were not available for an appointment. The patient was offered the option to wait until the notes were found or they could continue with the appointment with a set of temporary notes. The patient chose to wait until their missing notes were found and these were found on the day and the patient had her appointment after a three-hour wait.
- Regular audits of the quality of record keeping were undertaken against key performance indicators for tracking and availability of patient notes. The outpatient department reviewed 10 sets of patient notes each month for completeness and availability. Information

from the audits were presented in graphs and showed that patient notes were complete and available. We could not find evidence of actions taken following audits of record keeping.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at patient notes and patients were consented appropriately and correctly.
- Nursing staff told us they had completed Mental Capacity Act (2005) training. We found nursing staff understood the Mental Capacity Act (2005) (MCA) and how this related to outpatients in terms of best-interest decisions and the vulnerable adult.
- Medical staff we spoke with were unclear how the Mental Capacity Act related to outpatient care.

Safeguarding

- The trust had polices for safeguarding children and vulnerable adults. Staff were aware of the policies and procedures.
- 92% of outpatient staff had completed their safeguarding training.

Mandatory training

- We looked at staff mandatory training records. Records confirmed that 94.4% of staff were up to date with their mandatory training. The monthly review completed by the trust showed 92% of outpatient nursing staff had completed their mandatory training. And 86% of outpatients ophthalmology staff had completed their mandatory training in March 2014.

Management of deteriorating patients

- Staff on the Macmillan Unit had access to medical staff if a patient deteriorated while attending for chemotherapy treatment.

Nursing staffing

- The number of patients who attended clinics held each week was used to calculate the staffing need for the clinic.
- There were adequate numbers of nursing staff available to meet patient's needs. Nursing staff and patients told us there was always enough staff.
- We looked at the numbers for staffing agreed by the trust and these matched the number of staff working on staff rotas we looked at on the day of the inspection.
- The outpatient department tried to have the minimum standard for nurse to doctor ratio as one nurse to two doctors. However, sometimes due to absence/bank staff not turning up, it could be one nurse to three doctor's ratio. Staff escalated if bank staff did not arrive for shifts to the trust bank manager but they had not received any feedback from the escalation.
- Staffing levels for the Ophthalmology clinic on the day of the inspection were: three associate specialists, two qualified nurses and five health care assistants to one doctor and one registrar.
- Bank Staff had a general induction and were buddied with a permanent member of staff for the clinic
- Bank staff did not complete any clinical paperwork.
- The trust reviewed their sickness rates and in March 2014 outpatient nursing sickness rates were 17.3% but this has now reduced to 6.9% following staff leaving.
- Outpatient's ophthalmology sickness rates were 0.3%. It was identified for outpatient nursing there were two staff on long term sick.

Medical staffing

- Medical staff were managed by the speciality divisions such as medicine and surgery. The divisions review and manage mandatory training, supervision and appraisal.
- The trust used different locum medical staff to manage clinics for all weekend clinics.

Major incident awareness and training

- The trust had a business continuity plan dated 12 November 2013 and an overarching business continuity policy dated 25 April 2014.
- Key functions were set out in the plan in order of priority and these included bed management and site management. The plan outlined specific risks and a business impact analysis was included.
- Recovery time objectives (RTO) and maximum tolerable periods of disruption (MTPD) were not specified.

Are outpatients services effective?

Not sufficient evidence to rate

The outpatient department completed surveys and took part in clinical audits to improve the quality of the service. Performance information was monitored and readily available to staff and patients. The outpatient department supported and enabled multidisciplinary working and could demonstrate multidisciplinary care delivery met patient needs and delivered positive outcomes.

Outpatients

Evidence-based care and treatment

- The hospital had a patient pathway for orthopaedic and trauma patients which it audited for the complete patient pathway. Following the audit the outpatient department had implemented changes to the appointment system to improve the patient journey.
- The hospital had implemented changes to the pathway to improve the outpatient patient experience. Patients who attended the fracture clinic following an attendance at A&E were invited to attend the outpatient clinic the following day rather than being sent an appointment in the post.

Pain relief

- Patients on the Macmillan Unit had access to pain relief.

Patient outcomes

- The trust completed a trust-wide Ophthalmology Planned Care Outpatient Audit in April 2012 to assess the appropriateness of ophthalmology outpatient appointments in the hospital setting. Following results from a benchmarking exercise against trusts of similar size to NLAG had shown that the trust were seeing too many reviews.

Competent staff

- There were formal processes in place for staff to receive training and annual appraisals.
- Staff we spoke with confirmed they had received training and told us they had had an appraisal.
- The monthly review completed by the trust showed 74% of outpatient nursing staff had had their Professional Development and Appraisal Review (PDAR). 100% of outpatient's ophthalmology had had their Professional Development and Appraisal Review in March 2014. The trust identified that the PDAR rates in outpatient nursing was not compliant due to two staff being on long-term sickness.
- Revalidation for doctors was completed by the trust currently employs 47 Trust Grade doctors, 31 of which have been with them for less than a year and, therefore, will not have had a full year's service in a non-training grade post.

Multidisciplinary working

- There was a Specialist Nurse for ENT who has their own lists for aural toileting (ear cleaning).
- There were nurse-led clinics for visual field assessments in ophthalmology.
- There were nurse-led clinics in Dermatology for PUVA. The word "PUVA" comes from combining the words "psoralen" and "UVA." Psoralen is a medicine that makes the skin more sensitive to UVA light. PUVA therapy also may be called "photo chemotherapy." Dermatologists prescribe PUVA therapy when psoriasis does not respond to other treatments.
- There were nurse-led follow up clinics for planned replacement joint surgery run by two nurse specialists.

Seven-day services

- A number of outpatient clinics had run 'ad hoc' evening or weekend clinics to help them meet their targets. This showed that the outpatient clinics were responsive to the needs of patients and to their feedback. The trust ran extra clinics on a Saturday in March 2014. These included: Dermatology clinics four sessions, and Dermatology biopsies four clinic sessions.
- The trust also ran extra weekday clinic sessions. These included: Medicine 20 sessions, Surgery 4 sessions, Dermatology clinics 13 sessions and Dermatology biopsies 14 sessions in March 2014.
- Diana Princess of Wales Hospital was receiving 30 new referrals per week for ophthalmology clinic. The trust was running extra clinics bi-weekly clinics held by locum doctors from April 2014 to meet demand. With 40 new patients being seen 14 April 2014 and 70 new patients per week commencing 28 April 2014.
- In the Macmillan Unit a consultant appointment was kept free every day for emergency appointments.

Are outpatients services caring?

Good

Patients told us they felt involved in their care and treatment. Patients felt staff supported them with making difficult decisions. Patients told us they felt their privacy and dignity was respected

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- We looked at patient records and found they were completed sensitively and detailed discussions that had been had with patients and their relatives.
- The environment in the outpatient department allowed for confidential conversations.

Outpatients

- All patients were treated privately in consultation rooms.
- Chaperones were provided where required.
- Volunteers were available to provide assistance to patients.
- When patients had been identified as needing extra support this was flagged so staff could organise extra support at their appointment.

Patient understanding and involvement

- Patients stated they felt that they had been involved in decisions regarding their care.
- Patients told us they had no issues about the outpatient service. One patient told us, “Great service because of the friendly staff.”
- Patients told us they had opportunities to ask questions. Staff explained the treatment and patients were able to talk with staff about any concerns.
- The department held dementia drop in sessions to support patients and their relatives when attending the hospital for an outpatient appointment.

Emotional support

- Patients and relatives told us they had been supported when they had been told difficult diagnoses and had been given sufficient support.
- Outpatient staff ran a drop in clinic for patients with dementia and their relatives to discuss any concerns about outpatient appointments.

Are outpatients services responsive?

Requires improvement

The outpatient department understood the different needs of the communities it serves. The hospital monitored who used the service and the outcomes of care for the different population groups.

The trust monitored their Did Not Attend (DNA) rates at operational management level for Diana Princess of Wales Hospital. However, staff within outpatients were not aware of this. Staff we spoke to confirmed this, stating that they did not review DNA rates because these were managed by operational management staff and were not informed of the results. The trust had quite high levels of cancellation of outpatient appointments.

Service planning and delivery to meet the needs of local people

- The trust reviewed outpatient performance monthly. Performance reviewed includes: staffing levels and staff sickness, vacancy and use of bank staff.
- The hospital had introduced extra clinic sessions to meet the demand for patient referrals to ophthalmology.

Access and flow

- Referral to treatment times in less than 18 weeks for non-admitted completed pathways for this hospital was 96% against a target of 90%.
- The trust performed well in the 2011 Outpatient Survey in terms of how quickly it offered patients an appointment, its choice of appointment times and how it explained to patients what would happen at their appointment.
- The trust monitored their Did Not Attend (DNA) rates at operational management level for Diana Princess of Wales Hospital. The DNA rate was 10.5% for 2013–2014. However, staff within outpatients were not aware of this. Staff we spoke to confirmed this, stating that they did not review DNA rates because these were managed by operational management staff and were not informed of the results.
- However, in orthopaedic outpatients consultants would review DNAs and write in patients’ notes if patients needed to be sent another appointment, contacted by telephone or could be discharged. A DNA slip is also completed.
- Clinic and discharge letters were sent to GPs electronically within three days of the appointment.
- Patients had to request if they would like copies of their hospital letters.
- The outpatient clinics had signs saying “if waiting longer than 30 minutes please inform a member of staff”.
- We received information from the trust regarding cancelled appointments. This appeared to show that the trust had quite high levels of cancellation of outpatient appointments. The cancellation rate for this hospital was 17.1%.
- We spoke with the trust who told us the information should be treated with a note of caution. This was raw data which was taken from the CAMIS system and included issues such as patients whose appointment

had been changed within the same clinic, for example appointments changed from 3.30pm to 1.30pm, and appointments which have been changed or brought forward at the request of the patient.
- The trust told us they managed cancelled appointments weekly to ensure that any patient cancelled is re-appointed as appropriate. This was also discussed at the monthly business meetings for each group and oversight and challenge was provided at the Finance and Performance Committee and Trust Board. We saw evidence that appointment cancellations were discussed at the Finance and Performance Committee.
- The hospital scored 99.7% for referral to treatment for two-week standards in cancer.

Meeting people's individual needs

- There was good signage in the department.
- Information was displayed in the clinic advising patients of the waiting time.
- Volunteers assist patients with checking in for appointments and direct people to where ever they need to be within the hospital.
- Staff had access to a telephone translation line.
- The hospital had a dementia champion within the outpatient department.
- The trust had implemented a drop in clinic for patients with dementia and their relatives to allow them to ask about what would happen during their appointment,
- Staff was alert to potential support needs for vulnerable patients or those that needed extra support. Extra support would be available for learning disability patients.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints would be dealt with by the outpatient matron, but if this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS).
- We reviewed two complaints received and action plans. The trust responded to the complaint and an action plan was implemented and completed. Action from the complaint was that the outcome of the investigation was to be shared at a team meeting. However, we did not see evidence of any lesson learned being shared with staff.
- The staff tried to resolve patients' issues immediately.
- Staff explained the complaints procedure to us. However, complaint information was not easily available. We also found that PALs information was not on display in the department.
- The PALs service was located near the reception of the hospital. If patients did not feel confident about raising an issue it was not clear how they were made aware of the process to follow.

Are outpatients services well-led?

Good

The outpatient clinics focused on patient care. Staff understood the vision and values of the organisation. Staff and patient engagement was encouraged to achieve continuous improvement.

Vision and strategy for this service

- There was a leadership structure for the hospital and staff understood the structure, who their line manager was and who they reported to on the structure.
- Staff understood the strategy for the service.
- The executive directors and senior managers undertook announced and unannounced visits to outpatient areas to observe the running of the service. Following the visit and evaluation report is sent to the department visited.

Governance, risk management and quality measurement

- Quarterly team meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff. We looked at the minutes for September 2013, January 2014 and April 2014. The meetings looked at incidents, complaints and PALs information, staffing and service review.
- The outpatient department registered risks on the central operations risk register.
- The risk register was monitored through monthly central operations governance meetings. At Diana Princess of Wales Hospital it had been identified flooring within Radiology Waiting Area needed replacing. The flooring was identified as a low risk and flooring was to be monitored.
- High risks were monitored by the Trust Governance & Assurance Committee

Outpatients

Leadership of service

- There was a leadership structure for the department and staff understood the structure, who their line manager was and who they reported to on the structure.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff worked well together and there was obvious respect between not only the specialities but across disciplines.

Public and staff engagement

- The trust had taken part in the outpatient survey in 2011 and they had scored 8.6/10 for the overall experience in outpatients.
- Within the hospital there was 'you said, we did information' displayed on the wall telling patients of improvements. For example you said 'Poor food', we did 'New supplier'.
- The Patients' Satisfaction Survey was completed annually. Patient Satisfaction Survey for 2013 found patients wanted written information. Information sheet for ENT to be developed.
- Results from the 2013 NHS Staff survey placed the trust in the bottom 20% nationally for effective team working, for the percentage of staff who reported communication between senior management and staff.
- The hospital held quality safety days. In April 2014 the quality safety day reviewed complaints, incidents and claims, and central operations.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Nursing staff had completed specialist training in aural toileting and PUVA.
- Treatment sessions for PUVA had decreased from 30–40 to 18–25 sessions due to improvements in the use of equipment by the trained member of staff following training.
- The trust ran a best-practice day where staff displayed and shared experience. For example, the outpatient department.
- The consultants in orthopaedic outpatients reviewed DNA appointments and completed actions in the patient's notes.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The trust must:

- Ensure that there are sufficient qualified, skilled and experienced staff, particularly in A&E, medical and surgical wards. This is to include provision of staff out of hours, bank holidays and weekends.
- Review the skills and experience of staff working with children in the A&E department to meet national recommendations.
- Review the consistency of care and the level of consultant input, particularly out of hours and at weekends in the high dependency unit.
- Review care and treatment to ensure that it is keeping pace with National Institute of Health and Care Excellence guidance and best practice recommendations, particularly within the intensive therapy unit and high dependency units.
- Ensure that the intensive therapy unit uses nationally-recognised best-practice guidance in terms of consultant wards rounds and reviewing admissions to the unit.
- Review delayed discharges from intensive therapy unit in terms of the negative impact this can have on patients.
- Ensure that the designation of the specialty of some medical wards reflect the actual type of patients treated.
- Ensure that there is an improvement in the number of Fractured Neck of Femur patients who have surgery within 48 hours.
- Ensure there is appropriate care planning and a paediatric early warning scoring system on the neonatal intensive care unit and that there is consistent nutritional and tissue viability screening and assessment on paediatric wards.
- Ensure that all staff attend and complete mandatory training, particularly for safeguarding children and resuscitation.
- Ensure that staff have appropriate appraisal and supervision.
- Review the effectiveness of handovers, particularly in the medical services.
- Ensure that all patient documentation is appropriately updated and maintained including documentation for mental capacity assessments and risk assessments.
- Review access to soft diets outside of meal-times.
- Ensure that reasons for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) are recorded and are in line with good practice and guidelines.
- Ensure that DNACPR orders confirm discussion with patients or family members and whether multidisciplinary teams are involved before an order is put in place.
- Review the effectiveness of handovers, particularly in the medical services.
- Ensure that all patient documentation is appropriately updated and maintained including documentation for mental capacity assessments and risk assessments.
- Ensure that reasons for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) are recorded and are in line with good practice and guidelines.
- Review the 'did not attend' and waiting times in outpatients' clinics and put in steps to address issues identified.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to carry out the activity of TDDI, particularly in A&E, medical and surgical wards, including provision of staff out of hours, bank holidays and weekends, in order to safeguard the health safety and welfare of service users.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff There were not suitable arrangements in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard. Not all staff had attended and completed mandatory training, particularly for safeguarding children and resuscitation. Not all staff had received an appraisal or had appropriate supervision. Not all staff had the skills and experience to work with children in the A&E department to meet national recommendations.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services (1)The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – (a)The carrying out of an assessment of the needs of the service user; and (b)The planning and delivery of care and, where appropriate, treatment in such a way as to – 1. Meet the service user's needs, 2. Ensure the welfare and safety of the service user Not all patient documentation was appropriately updated and maintained including documentation for mental capacity assessments and risk assessments, including nutritional and tissue viability screening and assessment on paediatric wards. Not all reasons for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were recorded and in line with good practice and guidelines. Access to soft diets outside of meal-times must be reviewed. The 'did not attend' and waiting times in outpatients' clinics must be addressed and measures put in place to address the issues identified. The consistency of care and the level of consultant input, particularly out of hours and at weekends in the high dependency unit must be reviewed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Care and treatment must be in line with National Institute of Clinical Excellence guidance and best practice recommendations, particularly within the intensive therapy unit.

This section is primarily information for the provider

Compliance actions

The intensive therapy unit must use nationally-recognised best-practice guidance in terms of consultant wards rounds and reviewing admissions to the unit.

Delayed discharges from intensive therapy unit must be reviewed in terms of the negative impact this can have on patients.

The designation of the specialty of some medical wards must reflect the actual type of patients treated.

There must be an improvement in the number of Fractured Neck of Femur patients who had surgery within 48 hours.