Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust

Scunthorpe General Hospital

Quality Report

Cliff Gardens
Scunthorpe
Lincolnshire
DN15 7BH
Tel: 01724 282282
Website: www.nlg.nhs.uk

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

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Good
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

- There were significant gaps in the medical rotas for some specialities: both A&E and critical care services were not staffed in line with nationally recommended levels of consultants and A&E was not staffed to the trust's own recommended levels. The medical cover overnight at Scunthorpe was delaying care and treatment of some patients.
- Whilst the trust was actively recruiting to nursing posts, there remained a high number of nursing posts vacant on a significant number of wards and other services. Shift co-ordinators on each ward also had a cohort of patients to care for. On most wards there were two registered nurses overnight; frequently one of these would be bank or agency. We saw examples of delayed care and staff who were not familiar with ward environments and specialities. This was raised at the time of inspection and the trust are undertaking a review of nurse staffing and developing the shift co-ordinator role.
- There was a backlog of patients requiring outpatient follow up and high levels of clinic cancellations resulting in patients being cancelled on multiple occasions. There was a lack of clinical involvement in the cancellation process and a lack of clinical validation of the patients who were waiting for follow up appointments.
- There was lack of oversight and accountability of the outpatient processes and associated backlogs with actions slow and lacking sufficient senior managerial involvement at core service level. The issues regarding outpatient backlogs had been raised at the inspection and the trust took immediate action to ensure the backlog of patients were reviewed and provided with appointments.
- There were gaps in learning from incidents in almost all services. We were not assured that following serious incidents and never events that learning was disseminated and any risks identified and actions taken.
- At the time of the inspection the trust was a mortality outlier for deaths from acute bronchitis and cardiac dysrhythmias.
- There was no dedicated room in Scunthorpe ED specifically designed with safety measures in place that would allow for the safe assessment and care of patients who attended with a mental health condition. Other rooms that had been converted to treatment rooms were unsafe for patients on trolleys.

Summary of findings

- Within critical care essential equipment, such as beds, mattresses and ventilators, was old and described by staff as not fit for purpose. Twenty eight pieces of equipment required for direct patient care were out of date.
- Staff were not aware of how to record minimum and maximum temperatures for medication fridges; what the recommended range was or that this was necessary for safety and efficacy of the medicines. We saw several examples were a temperature had been recorded outside of recommended range but no action had been taken.
- There had been managerial change within critical care which was beginning to have a positive impact with regard to development of critical care services.
- There was not sufficient resource identified, including specialist staff, training and systems in place to care for vulnerable people, specifically those with learning disabilities and dementia. However, there was a highly motivated and compassionate quality matron who had the lead for dementia and also learning disabilities.
- At our inspection in April 2014 we found that not all clinical staff had received safeguarding of children training up to the advanced level three. At this inspection, we found that clinical staff were now in the process of being trained up to level three in safeguarding children. However, the numbers of staff who had received the level three training was below the trust's 95% target. The records provided to us by the trust showed that no medical staff in the emergency department had undertaken level three safeguarding children training.
- Scunthorpe General Hospital scored well in the Stroke Sentinel National Audit Programme, with an overall score of B (on scale of A – E, with E being the worst) for April – June 2015 admissions.

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

- The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. This must include but not be limited to: medical staff within ED and critical care, nursing staff within ED, medicine and surgery. It must also include a review of dedicated management time allocated to ward co-ordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service.
- The trust must ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need, ensure that the governance and monitoring of outpatients' appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment.
- The trust must ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to: staffing; critical care and ensuring the essential equipment is included in the trust replacement plan.
- The trust must ensure that staff at core service/divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas. The trust must improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform.

Summary of findings

- The trust must ensure it acts upon its own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development.
- The trust must ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas.
- The trust must ensure that all risks to the health and safety of patients with a mental health condition are removed in Scunthorpe emergency department. This must include the removal of all ligature risks, although must not be limited to the removal of such risks. The trust must undertake a risk assessment of the facilities, including the clinical room and trolley areas, but not be limited to those areas with advice from a suitably qualified mental health professional.
- The trust must ensure that the recently constructed treatment rooms at Scunthorpe that were previously used as doctors' offices are suitable for the treatment of patients on trolleys. This must include ensuring that such patients can be quickly taken out of the room in the event of an emergency.
- The trust must have a process in place to obtain and record consent from patients and/or their families for the use of the baby monitors in ITU.
- The hospital must ensure the safe storage of medicines within fridges. The trust must ensure staff check drug fridge temperatures daily and record minimum and maximum temperatures. Additionally it must ensure staff know that the correct fridge temperatures to preserve the safety and efficacy of drugs and what action they need to take if the temperature recording goes outside of this range.
- The trust must ensure equipment is checked, in date and fit for purpose including checking maternity resuscitation equipment and critical care equipment is reviewed and where required included in the trust replacement plan.
- The trust must ensure there is an effective process for providing consistent feedback and learning from incidents.
- The trust must review the validation of mixed sex accommodation occurrences, to ensure patients are cared for in appropriate environment and report any breaches.
- The trust must ensure the reasons for do not attempt cardio respiratory resuscitation (DNACPR) decisions are recorded and in line with good practice within surgical services.
- The trust must ensure the five steps for safer surgery including the World Health Organisation Safety Checklist (WHO) is consistently applied and practice is audited in theatres.
- The trust must review the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre and the number of on the day cancellations for patients awaiting operation.
- The trust must ensure policies and guidelines in use within clinical areas are compliant with NICE guidance or guidance from other similar bodies and that staff are aware of the updated policies, especially within maternity, ED and surgery.
- The trust must ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia. The trust must stop using newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty.
- The trust must ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours The trust must continue to improve against the target of all staff receiving an annual appraisal and supervision, especially in surgery, and that actions identified in the appraisals are acted upon.

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

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We found the service to be requires improvement overall. - Since our last inspection in April 2014 the trust had done little to improve the premises. The premises were unsafe for patients with a mental health condition because rooms used to assess them, and in which they waited for assessment, had ligature points; places where a person intent on self-harm could tie something to strangle themselves. Treatment rooms recently converted from doctors' offices had not had their doors widened to allow for patients on trolleys to be taken out quickly in an emergency. The children's waiting room had limited space and there was no barrier to prevent inappropriate access. There was no designated treatment area for children and young people apart from one clinic room also used for adult patients. There was no entrance for patients attending with minor injuries or illnesses separate from that used for ambulance patients brought in with serious injuries. - The service was not staffed in line with nationally recommended levels of consultant cover, or to the trust's own levels. Although the trust told us there was 11 hours' per day consultant presence in the department we found this did not occur at the weekend. On Saturdays and Sundays the consultant presence was for three hours. We also found limited consultant presence in the department on bank holidays. There were 21% of nursing posts vacant. The department was not meeting the Royal College standards regarding paediatric nursing staff. Whilst safeguarding training levels 1 and 2 had improved, they were still low for level 3. - Whilst the department had in place best practice guidelines including those produced by the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine not all had been fully implemented or audited. Between April and July 2015, 871 (8.4%) out of 10,354 patients waited longer than 30 minutes before being handed over from the care of ambulance staff

Summary of findings

to emergency department staff. Between April 2015 and November 2015 the national standard to achieve 95% of patients being seen in ED and a decision made to treat, discharge or admit within four hours was at or above the standard trust-wide in June, July and September 2015.

- The leadership had not acted promptly or adequately on the concerns raised from our last inspection. Governance was inadequate. Whilst there were trust-wide governance and risk management systems in place down to directorate level they were not operating effectively within the department or its directorate. None of the key risks highlighted by the inspection team had been identified on either the directorate risk register or the trust's corporate risk register.

Medical care (including older people's care) — **Requires improvement**

We rated medical services as 'requires 'requires improvement' overall. Safe and responsive were rated as 'requires improvement'. Effective, caring and well-led were rated as 'good'.

- Staffing levels were often below the minimum agreed level required to provide safe care. We saw occurrences when there were only one registered nurse and two health care assistants on a ward overnight to look after 28 patients. Although managers were trying to minimise risk to patients we heard call bells left unanswered for 10 minutes and a patient told us there had been a delay in receiving pain relief because nurses were so busy.
- Feedback and learning from incidents was not consistent across the hospital, with many staff saying they did not receive any feedback.
- Medicines were mostly well managed but there was an issue with the monitoring of fridge temperatures on most wards.
- Some issues negatively affected patient access and flow.There were issues with flow through the hospital with Ward 2 (Short Stay Ward) and the clinical decisions unit often being unable to move patients to the most appropriate ward. It was reported that it was often difficult to re-patriate stroke patients back to their local hospitals due to bed capacity problems.
- Mandatory training levels had improved for nursing staff. However, training levels for medical staff fell significantly below the trust target.

Summary of findings

- Quality audits were completed every month on each ward and any areas of concern were addressed with an action plan. The trust participated in national clinical audits scoring well in the Stroke Sentinel National Audit Programme, with an overall score of B.
- There was improvement in the number of medical and nursing staff who had a managerial appraisal of their work performance.
- Patients received compassionate care and were treated with dignity and respect. Their privacy was preserved. Patients and relatives we spoke with felt very happy about how they were looked after and said staff were kind, caring and patient.
- Since July 2014, referral to treatment time in this trust has been above the 90% standard in all specialties measured.
- The wards we visited appeared well organised and managed. Action had been taken on wards that had been previously failing, which had led to improvements. Staff spoke well of their line managers and found them to be supportive.

Surgery

Requires improvement

We rated surgery as 'requires improvement' overall. This was because:
- Surgical services did not always protect patients from avoidable harm and there was a limited level of assurance with safety measures.
- In 2014, we said the trust must take action to ensure that there was sufficient qualified, skilled and experienced staff, particularly in surgical areas. During this inspection, we found substantial and frequent shortages of nursing staff and an increased number of agency staff being used. When staff shortages occurred, the skill mix of staff was not always a priority.The trust had run a significant recruitment campaign but the skill mix and retention of new staff remained an issue. Newly qualified nurse, awaiting their national registration, were often included within the qualified staffing levels. Many staff commented on an increased amount of pressure for experienced/ substantive staff due to staff shortages. The overall number of vacancies had increased since our inspection in 2014 despite the trust's efforts at recruitment.

Summary of findings

- We found that although staff reported incidents, the lessons learned from investigating them were not always fed back or shared effectively with all surgery staff, to help prevent the incidents from happening again.
- We had concerns regarding the pre-assessment of patients; the assessment of early warning scores for deteriorating patients; and the provision of emergency equipment. Assurance for compliance with the team brief element of the five steps for safer surgery was limited.
- Patients were at risk of not receiving effective care or treatment, as care provided did not always reflect current evidence-based guidance, standards and best practice. Implementation of best practice guidance was variable, with 65% of policies compliant with current National Institute for Health and Care Excellence guidance as of September 2015.
- National hip fracture audit data for 2014 showed SGH performed better than the England average on most of the indicators. However, there had been deterioration in performance at SGH in six of the areas reported on in 2014 compared to 2013.
- Appraisal rates had improved since 2014, however still did not meet internal compliance targets and levels of compliance across surgical wards and departments were variable.
- Services did not always meet patients' needs. They were not always able to access services for assessment, diagnosis or treatment when they needed them. There were long waiting times, especially in urology, pain procedures, ophthalmology and trauma and orthopaedics. Patients we spoke to and evidence we reviewed showed that patients were experiencing delays and cancellations of operations and procedures. Actions taken to deal with this were not always timely or effective. A number of medical patients were using surgical beds, which limited the availability of beds for surgical patients.
- Patients' needs were not always taken into account. Patients were not always able to access services for assessment, diagnosis or treatment when they needed to. There were long waiting times for some specialities.There was no surgical vision statement or overarching surgical strategy.

Summary of findings

We were told that some of the future service provision would be determined through the ongoing local health community "Healthy Lives, Healthy Futures" work stream. Risk issues were not always dealt with appropriately or in a timely way.
- It was noted in the 2014 inspection, that the senior management team was new at that time and had not had time to implement changes. During 2015 further change to the senior management team had taken place. Managers had not yet identified, prioritised and taken action on all of the issues of concern within surgery. Potential improvements from the introduction of the quality and safety days had not yet become an established route for learning.
- During the inspection, we saw improved leadership on surgical wards from ward managers.
- The development of the Web V virtual ward administration computer system had made a positive impact on the documentation of patient risks.

Critical care

Requires improvement

Overall, we rated critical care as 'requires improvement'. Safe, effective, responsive and well-led we rated as 'requires improvement' and caring was rated as 'good'. There was no improvement in the ratings from the 2014 inspection to this inspection.
- Essential critical care equipment such as beds, mattresses and ventilators was old and described by staff as not fit for purpose. This had been added to the surgery and critical care risk register in 2009. There was no evidence that any action had been taken and funding was not available for replacement in 2015/16 capital program.
- Twenty eight pieces of equipment required for direct patient care were out of date. Oxygen cylinders were not stored in line with national guidance.
- The unit did not meet the requirements of national standards for nurse or medical staffing. A consultant intensivist was not available seven days and week and medical staff rotas did not promote continuity of care. A supernumerary senior nurse

Summary of findings

was not available 100% of the time as a clinical coordinator. The clinical educator post had been vacant for eighteen months at the time of our inspection.
- Patient outcome data for the ITU was variable; the mortality ratio was worse than the critical care network average data.
- Staff showed limited application of putting policies into clinical practice, for example, patient consent and restraint.
- The bed occupancy was higher than the national average. The number of delayed discharges was higher than the critical care network average. Staff reported 10 incidents of mixed sex accommodation occurrences due to delayed discharges. Forty two elective operations were cancelled due to a lack of critical care bed and 46 patients were ventilated outside the unit. There were eight non-clinical transfers in the six months prior to our inspection This was not in line with recommendations from Core Standards for Intensive Care (2013).
- The management team had not taken timely action on some of the issues identified on the risk register. Ageing and failing equipment that had an effect on patient and staff safety within ITU such as beds and ventilators had been on the risk register for up to six years. From the records of the service governance meetings we saw little evidence to suggest leaders reviewed the risk register or developed actions to mitigate risk.
- Morale varied across staff groups with themes being around changes to clinical leadership and working patterns
- Recent changes had been made to the clinical leadership and time was needed to engage all staff in the changes and embed the new structure of leadership.
- Some progress had been made to cross site working and standardisation of evidence based care across both sites.

Maternity and gynaecology

Good

Overall, maternity and gynaecology services were rated as' good'. We rated the service' good' for safe, effective, caring, responsive and well-led. This was because:

Summary of findings

- Staff were encouraged to report incidents and the majority told us they had received feedback from incidents in newsletters, emails, in team meetings and one to one meetings with their manager when they had been involved.
- There had been several changes in management and the three hospital sites were now working more collaboratively, attended joint meetings and shared good practice.
- The birth to midwife ratio was 1:25 and this was better than the national average of 1: 28.
- Women received one to one care during labour and their pain relief of choice was available.
- Women received care according to professional best practice clinical guidelines.
- In September 2015, positive feedback was received from the results of the NHS Friends and Family Test (FFT). Between91% - 100% would recommend the services.
- At the Royal College of Midwives award in 2014, the midwifery team was recognised twice for promoting a 'normal birth experience' and were finalists in the 'supervisor of midwives team' category.

However, we also found:

- Some policies were out of date; this had been identified by the provider and steps had been taken to address the situation.
- The checks of emergency equipment were not being done consistently across all areas. This meant the equipment may not have been available in an emergency.
- The Kirkup Report gap analysis of the service had identified the need for a Clinical Risk Midwife and a Practice Development Midwife. However, although the management team were working on this, neither had been appointed.

Outpatients and diagnostic imaging

Inadequate

We found the outpatients and diagnostic imaging core service to be rated as 'inadequate' overall because:

- There was evidence of harm to patients within the outpatient services because of poor management of the follow up appointment system. There were

Summary of findings

no significant concerns identified within the diagnostic services we inspected; we found patients were protected from avoidable harm and received effective care.

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

- There was a trust-wide backlog of 30,667 outpatients without follow-up appointments, the majority were in ophthalmology. At the time of the inspection the service had no clear action plan to address the immediate clinical risk to patients.

- The number of patients who did not attend outpatient clinics was above 10% and the number of cancelled clinics in outpatients and ophthalmology had increased since the last inspection. The did not attend rate was much lower in radiology at SGH between 1 October 2014 and 30 September 2015 was 2.47%. There were a high number of cancelled appointments with some appointments cancelled on the day. There was also evidence that the decisions to cancel appointments had no clinical input.

- The trust undertook a validation exercise to identify and prioritise those patients who required an appointment in ophthalmology. The trust assured us that all of the 441 outstanding ophthalmology patients would have appointment dates and their appointments completed by 31 December 2015.

- For specialities other than ophthalmology a similar system was to be implemented and again the trust assured us that all patients needing an appointment would have one booked by 31 December 2015. The latest information from the trust indicated that all patients had been validated and those requiring appointments had been given them or would be at the required time .

- Services provided by the radiology departments and trust policies were based on nationally

Summary of findings

recognised guidance such as NICE and Royal College guidelines. Staff in radiology were competent to carry out their roles, and there was evidence of multidisciplinary working.

- During our inspection, patients and relatives commented positively about the care provided from all of the outpatients and diagnostic imaging staff. Staff working in the departments treated patients politely and with respect.

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

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

- Staff in both departments told us their line managers were supportive. Staff and line managers both told us there was an open culture and good teamwork within the departments. However, there was a lack of management oversight of the significant problems with the OP clinic booking systems.

Scunthorpe General Hospital

Detailed findings

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

Detailed findings

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Background to Scunthorpe General Hospital

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

CQC carried out a comprehensive inspection between 23 and 25 April and on 8 May 2014 because the Northern Lincolnshire and Goole NHS Foundation Trust was placed in a high risk band 1 in CQC's intelligent monitoring system. The trust was also one of 14 trusts, which were subject to a Sir Bruce Keogh (the Medical Director for NHS England) investigation in June 2013, as part of the review of high mortality figures across trusts in England. Overall, Scunthorpe hospital was found to require improvement, although CQC rated it as good in terms of having caring staff.

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included: CQC inspectors and a variety of specialists, namely, Community Trust CEO/Director, Community Children's Nurse Manager, Community Matron, Health Visitor, School Nurse, Dentist, Community Paediatrician, Physiotherapist, District Nurse, Child Safeguarding Lead Nurse, EOLC Matron, Critical Care Doctor, Critical Care Nurse, A&E Nurse, Medicine Doctor, Medicine Nurse, Surgery Doctor – Surgeon, Surgery Doctor – Anaesthetist, Surgery Nurse, Theatre Nurse, Ophthalmic Nurse – Outpatients, Midwife Matron, Midwife, Consultant Obstetrician, Child Safeguarding –

Detailed findings

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

How we carried out this inspection

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

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

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

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

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

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

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

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

Facts and data about Scunthorpe General Hospital

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

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

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

Detailed findings

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

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

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

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

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

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

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

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

During an inspection of this service in April 2014, we found it required improvement in relation to being safe, responsive and well led. In October and November 2015, we did a focused follow-up inspection and an unannounced inspection to see whether improvements had been made. We also inspected and rated the effectiveness of the service, as this was not rated during our inspection in 2014.

The emergency department saw 63,707 patients between April 2014 and March 2015, an average of 180 patients a day. Twenty per cent of patients (12,741) were children under 16. Between April 2015 and September 2015, the department saw 32,926 patients; 5,945 (18%) of whom were children. Of the total attendances over this period, 8,353 (25.4%) patients were admitted. The department treated all emergencies except major trauma. The emergency department was open 24 hours a day, seven days a week.

The department was divided into areas for the treatment of minor and major illness and injury and for resuscitation. There were four bays in the resuscitation room, one of which was used for children. In the major cases area there were eight cubicles, four of which were classified high observation cubicles for the sickest patients in that area. In the minor cases area there was a triage room and six treatment rooms. There was an area for patients who were waiting to be discharged or to go to a ward, and a recently constructed area where ambulance crews could wait with patients before handover. The treatment rooms were used by emergency nurse practitioners (ENPs), emergency department doctors and GPs. They included a room for the treatment of children and an eye examination room.

During our inspection, we spoke with eight patients and relatives, and 36 members of staff. We observed care and treatment being undertaken. We also reviewed clinical records, and policies and procedures.

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

Urgent and emergency services

Summary of findings

We found the service to be requires improvement overall.

- Since our last inspection in April 2014 the trust had done little to improve the premises. The premises were unsafe for patients with a mental health condition because rooms used to assess them, and in which they waited for assessment, had ligature points; places where a person intent on self-harm could tie something to strangle themselves. Treatment rooms recently converted from doctors' offices had not had their doors widened to allow for patients on trolleys to be taken out quickly in an emergency. The children's waiting room had limited space and there was no barrier to prevent inappropriate access. There was no designated treatment area for children and young people apart from one clinic room also used for adult patients. There was no entrance for patients attending with minor injuries or illnesses separate from that used for ambulance patients brought in with serious injuries.
- The service was not staffed in line with nationally recommended levels of consultant cover, or to the trust's own levels. Although the trust told us there was 11 hours' per day consultant presence in the department we found this did not occur at the weekend. On Saturdays and Sundays the consultant presence was for three hours. We also found limited consultant presence in the department on bank holidays. There were 21% of nursing posts vacant. The department was not meeting the Royal College standards regarding paediatric nursing staff. Whilst safeguarding training levels 1 and 2 had improved, they were still low for level 3.
- Whilst the department had in place best practice guidelines including those produced by the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine not all had been fully implemented or audited. Between April and July 2015, 871 (8.4%) out of 10,354 patients waited longer than 30 minutes before being handed over from the care of ambulance staff to emergency department staff. Between April 2015 and November 2015 the national standard to achieve 95% of patients being seen in ED and a decision made to treat, discharge or admit within four hours was at or above the standard trust-wide in June, July and September 2015.
- The leadership had not acted promptly or adequately on the concerns raised from our last inspection. Governance was inadequate. Whilst there were trust-wide governance and risk management systems in place down to directorate level they were not operating effectively within the department or its directorate. None of the key risks highlighted by the inspection team had been identified on either the directorate risk register or the trust's corporate risk register.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated the service as 'requires improvement' overall.

- This was because of concerns regarding the care of patients with mental health conditions, the environment and staffing.
- We found that the environment was unsafe for patients that presented with a mental health condition. The rooms used to assess these patients, and in which they waited for assessment, had ligature points that could be used by a person with suicidal ideation to harm themselves. Treatment rooms that had recently been converted from doctors' offices had not had their doors widened to allow for patients on trolleys to be taken out quickly in an emergency. There was a waiting room for children although space was limited and there was no barrier to prevent inappropriate access. There was no designated treatment area for children and young people apart from one clinic room that was also used for the treatment of adult patients.
- The service was not staffed in line with nationally recommended levels of consultant cover, or to the trust's own levels. Although the trust told us there was 11 hours' per day consultant presence in the department we found this did not occur at the weekend. On Saturdays and Sundays the consultant presence was for three hours. We also found limited consultant presence in the department on bank holidays. There were 21% of nursing posts vacant and the service was not meeting the requirements for children's nurses in the emergency department. Whilst safeguarding training levels 1 and 2 had improved, they were still low for level 3. Staff were aware of the trust's incident reporting system however, not all staff received feedback about incidents and lessons to be learned from them.
- There were 86% of patients arriving by ambulance for the period April 2015 to October 2015 who were clinically assessed within 15 minutes.
- Nursing staff used patient group directions in order to administer drugs. However, we found that not all the patient group directions had been recently reviewed.

Incidents

- Staff were aware of the trust's incident reporting system and told us they knew how to report incidents of harm or risk of harm. However, not all staff received feedback about incidents and lessons to be learned from them, especially if they had not occurred in the emergency department. This was exacerbated by not all nursing staff having access to emails, which was the way information was shared. The senior nurse in the emergency department told us they were in the process of ensuring all staff had email addresses.
- We reviewed meeting minutes that showed incidents were discussed at unplanned care business and governance meetings attended by senior staff. Feedback to staff who did not attend these meetings was through an informal "huddle" before the start of each nursing shift at which incidents were discussed. We observed these "huddles" taking place.
- There had been no 'never events' at Scunthorpe ED. (These are serious, largely preventable patient safety incidents that should not happen if the available preventative measures have been used), However, there had been one at the trust's other emergency department in Grimsby. We spoke with six members of staff of varying grades but only one was aware of the incident.
- Between May and August 2015, the emergency department reported no severe incidents and seven moderate incidents. Two of these related to patients attending the department with pressure sores, whilst the others related to clinical issues, communication and the provision of IT services.
- In May 2015 there was a report concerning long waits in the department. This included 13 patients waiting for medical beds, and 10 ambulance patients waiting to be handed over. The action taken included escalation to the bed manager and to the ambulance service manager. This was graded as very low which may have meant it was not prioritised for timely action and learning,

Duty of candour

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

Cleanliness, infection control and hygiene

- During our inspection in April 2014 staff were not cleaning their hands between patients. During this inspection, staff cleaned their hands between patients and on all other appropriate occasions.
- There were hand washing facilities and hand cleaning gel throughout the clinical areas of the department.
- Bins were clean and not overfull and there were adequate bins for both clinical and general waste. All sharps' bins were below the marked level.
- However, toys and play equipment in the children's waiting room were not clean. Some of them were made of material that made them difficult to keep clean while others seemed to be very old. We were also not able to find a cleaning log for the cleaning of the toys and play equipment. Toys and play equipment handled by children, especially sick children, should be cleaned regularly and toys that cannot be cleaned effectively should be disposed of.
- There were no reported cases of clostridium difficile or methicillin-resistant staphylococcus aureus (MRSA) within the department from April 2015 – October 2015.
- We reviewed the results of hand hygiene audits undertaken in the department between January and July 2015. In January, February, May and June 100% compliance was recorded. However, in March, April and July there was no record of any hand hygiene audits having been undertaken. This evidence showed that although when hand hygiene was audited the results were positive they did not take place on a regular monthly basis. To give an effective picture of compliance with hand hygiene procedures and expectations audits should be undertaken on a regular basis.
- Between January and July 2015 environmental infection control audits were undertaken in the department. We reviewed these audits which had action plans, with details of when actions were completed, for areas that required attention.
- In the 2014 patient survey of emergency departments patients scored 8.5 out of 10 when asked if the department was clean. This was organised on a trust-wide basis and included the emergency departments at Grimsby and Scunthorpe.
- The level of infection control training for the directorate of medicine, of which the emergency department was a part, was at 76% for nursing staff against a trust target 0f 95%. Medical staff had achieved 100%.
- In the resuscitation room at both sites we found that airway management equipment was not in sealed sterile packaging. This equipment should be kept in sealed packaging to keep them sterile.

Environment and equipment

- At our inspection in April 2014 we found there was no dedicated room specifically designed with safety measures in place that would allow for the safe assessment of patients who attended with a mental health condition. At this visit we found there was still no room designed for this purpose. We were told by senior staff that either a curtained room in the majors' area or one of the treatment rooms, which were entered through a door, were used. Neither of these rooms had safety measures such as a second door for emergency exit, or an emergency alarm. They also had ligature points that could be used by a person with suicidal ideation to harm themselves. There were coat hooks, leads for monitors and electrical leads that posed a risk of avoidable harm. There were also bandages and plastic aprons which could be used to make a noose.
- A Royal College of Emergency Medicine (RCEM) audit undertaken in 2014/15 reported under fundamental standard 7a that there was no "dedicated assessment room for mental health patients". Because of this the department failed to meet developmental standard 7b; which asked whether the room met all standards set out by the Psychiatric Liaison Accreditation Service.
- We informed the trust of our concerns for the safety of mental health patients because of the lack of safe assessment and treatment rooms, both at the time of the inspection and again at the unannounced inspection in November 2015. The trust sought advice from specialists and provided us with a plan to improve the safety and care of patients with mental health conditions.
- At our inspection in April 2014 we found there was no area for children separate from adults in the waiting room. During this inspection we found that an already existing children's play room had been redecorated and a wall built outside of it which partially separated it from the waiting area. However, space for children to wait in the room was limited. There were also three small chairs between the play room and the wall although these directly faced the adult waiting room and were only partially separated by the wall. There was no barrier to prevent inappropriate access, however there was a

security office next to the room which gave some element of protection for children. We were told by senior managers that plans were being developed to provide a completely separate waiting room for children.

- We found there was no separate treatment area for children and young people apart from one clinic room. However, this room was also used for the treatment of adult patients by GPs, and other health care professionals.
- When we visited the department in April 2014 we found there was one entrance for patients brought in by ambulance and those walking in to be booked-in at reception. This meant that the privacy and dignity of patients with serious injuries was compromised. It was also the case that people walking into the department, including children, could see seriously injured patients, which could cause distress. We also found that the signage which directed patients to reception was not well signposted. At this inspection we found that although no building work had been undertaken the senior managers responsible for the service told us that a plan had been developed to create two entrances, so that ambulant and ambulance patients would come in at separate entrances. We found no documentary evidence of these proposed changes. However, we found that the signage had been improved.
- In April 2014 we also found that the resuscitation room was too small for its purpose. This was because it was used by another department for the treatment of stroke patients, as well as for resuscitation and the treatment of trauma cases. At this inspection we found that the area was not routinely used for the treatment of stroke patients freeing up space for resuscitation and trauma.
- Following our visit in April 2014 the trust had altered three doctors' offices so they could be used as treatment areas. However, the doors had not been widened so as to allow the safe transfer of patients on trolleys in the event of an emergency. Staff told us that it took time to get the trolleys out of the rooms and they had to be manoeuvred in a certain way.
- We informed the trust of our concerns that the rooms were unsafe. They responded by providing us with an action plan to prevent acutely ill patients using these rooms. They also told us they would be widening the doors to improve the speed with which patients could be taken out of the room in an emergency.
- On a weekday evening shift we observed there were sufficient staff but were not enough treatment bays and rooms to see patients in. This corresponded to what we were told by staff, who told us that if they had more treatment areas they would be able to see patients quicker.
- During our inspection we observed patients being transferred through a dark corridor lined with boxes and a vacuum cleaner. We also saw that one of the fire extinguishers was blocked by a trolley. Fire extinguishers should not be blocked in order to ensure they are always readily available.

Medicines

- Nursing staff used patient group directions in order to administer drugs. However, we found that not all the patient group directions had been recently reviewed. In order for medicines to be managed safely patient group directions must be reviewed on a regular basis.
- We found that controlled drugs were correctly stored and administered. Appropriate records were kept including a record of the disposal of out of date drugs.
- We checked a sample of drugs in the drug cupboards and found them to be in date.
- However, we found that on two occasions in October and November 2015 controlled drugs that had been administered to patients had not been signed by two members of staff. Controlled drugs that are given to patients should be signed by the person administering the drug and by a witnessing counter signatory.
- Drugs' fridges were temperature controlled and the temperatures were regularly recorded in line with recommended guidelines. The recorded temperatures were at the correct levels. However, not all staff we spoke with were aware what the correct temperature was.
- There had been a recent incident where drugs had gone missing. We found this had been appropriately investigated and measures were put in place in order to reduce the risk of this happening again.
- We found that prescription pads were locked in the drugs cupboard to prevent inappropriate use.
- There was a flip chart that had been devised to provide easily accessible information on drug dosages and interactions.
- All the medical gas cylinders that we inspected were within safe working limits and had current safety stamps.

Urgent and emergency services

Records

- Emergency department records were prepared for each patient that attended the department.
- Patient records were prepared by the department for the transfer of patients to the ward so that a full set of notes accompanied each patient when they transferred to the ward.
- We observed nursing and medical staff completing patients' clinical records appropriately and safely.
- We found that agency staff could not use the trust's computer systems and databases. This therefore meant that trust staff had to make entries for them which led to delays in getting blood test results and getting other clinical information.

Safeguarding

- Staff were aware of how to report safeguarding incidents on the electronic reporting system. They were also aware of the processes for the investigation of suspected safeguarding incidents.
- There were systems in place for the reporting of safeguarding incidents relating to both adults and children. Staff had electronic access to the safeguarding registers for both adults and children, and told us they had a good working relationship with social services safeguarding teams.
- At our inspection in April 2014 we found that not all clinical staff had received safeguarding of children training up to the advanced level three. At this inspection, we found that clinical staff were in the process of being trained up to level three in safeguarding children. However, the numbers of staff who had received the level three training was below the trust's 95% target.
- The records provided to us showed that 25% of medical staff in the emergency department had undertaken level three safeguarding children training. Records also showed that 75% of medical staff had undertaken levels one and two of safeguarding children training.
- With regard to nursing staff the records we were provided with referred to "SGH Medical Ward A&E (2622)". We understood this to refer to nursing staff in the emergency department. The percentage of this staff group that had received level three safeguarding children training was 63%. Ninety eight percent of this group of staff had undertaken level one and two safeguarding children training.
- The percentage of non-clinical administration and reception staff in the department who had undertaken level one safeguarding training was 86%.
- We were also provided with the figures for staff who had received safeguarding adults training. This was all at level one and stood at 60% for medical staff, 85% for nursing staff: "SGH Medical Ward A&E (2622)", and 82% for administration and reception staff.
- It was therefore the case that in the majority of instances the trust target of 95% of staff having received this training had not been met.

Mandatory training

- Staff we spoke with told us that their mandatory training was up-to-date or they were booked onto courses.
- Senior staff in the department told us that the level of mandatory training for nursing staff was at 81%, which was below the trust target of 95%.
- Records provided to us by the trust were for the directorate of medicine, of which the department was a part, were between 15% and 100%. The 15% was for medical staff who had taken blood transfusion training.

Assessing and responding to patient risk

- There was a system for assessing ambulance patients that arrived in the department although we found that when the department was busy there was a delay in the assessment taking place. Ambulance crews told us that on such occasions they had to go round to the nurses' station in the majors' area to find a nurse to assess the patient. We observed this when we visited the department.
- Nursing staff told us that they did not assess patients until they were able to be handed over by the ambulance crew, although they told us they were aware of their condition when ambulance staff booked them in.
- Times to initial assessment were provided by the trust on a trust-wide basis and included Scunthorpe General Hospital and Diana Princess of Wales Hospital emergency departments; and the minor injuries unit at Goole District Hospital. The trust data for the median time to initial assessment of ambulance patients between April 2014 (the time of the last inspection) and April 2015 ranged between zero minutes in April 2014 and one minute in April 2015.
- Over the same time frame information indicated that patients waited between 40 and 50 minutes following

assessment before treatment was commenced. Although these figures were better than the median figures for emergency departments in England as a whole they showed long waits between assessment and treatment.

- The trust provided data for the clinical assessment of patients arriving by ambulance for the period April 2015 to October 2015. Out of a total of 10,354 patients 8,961 (86.6%) were assessed within 15 minutes whilst 9,780 were assessed within 30 minutes. The number of patients who waited more than 30 minutes to be assessed was 871 (8.4%). Out of this number 148 waited over an hour to be assessed. One patient waited over four hours to be assessed whilst 12 waited more than two hours.
- During an evening visit we saw that two patients who waited long periods of time in the ambulance handover area without being assessed by emergency department staff. One of these patients waited for over one hour whilst the other waited for just under one hour. One of the patients had come in with chest pain and although they arrived at 7.45pm they were not assessed or had an ECG performed until 9pm.
- There was a single point of access (SPA) based by ED reception, which was staffed by a nurse with support from ED doctors. The SPA managed the assessment of referrals from GPs and the 111 NHS telephone advice service. Patients that required a bed would go directly to the ward unless there were no beds in the hospital, in which case they would come to the emergency department. Patients coming through this stream that had a minor illness or injury would be seen by the GPs who worked in the department.
- Patients that attended the emergency department with minor injuries or illness could be seen after initial triage assessment by an emergency department doctor, an emergency nurse practitioner (ENP) or a GP.
- Patients that walked into the department but following triage were found to have a more serious illness or injury were taken round to the majors' area or the resuscitation room.
- Recognised clinical risk recording tools, such as MEWS (modified early warning score) and PEWS (paediatric early warning score), were used to record patients' vital signs, and describe any deterioration in their condition and the actions taken.
- Systems were in place for escalating care when a patient's clinical condition deteriorated.
- There was a sepsis screening tool for the management of patients attending with a suspected diagnosis of sepsis.
- Handovers where assessments of patient risk were discussed took place in the form of huddles where the nursing shifts would discuss the patients in the department and their clinical condition. We observed these huddles and found that appropriate information was passed over.

Nursing staffing

- The trust provided establishment levels for July 2015 which showed an establishment of 72.94 whole time equivalent (WTE) registered nurses and healthcare assistants (HCA's). There were 57.16 WTE in post which left a variance against establishment of 15.78 WTE. This meant that 21% of nursing posts were vacant.
- With regard to registered nurses the establishment levels for July 2015 showed an establishment of 57 WTE. There were 44.34 WTE in post which left a variance of 12.66 WTE. This meant that 22% of registered nursing posts were vacant.
- The matron for medicine who was responsible for the leadership management of the emergency department nursing team told us they used a nationally recognised staffing tool to assess staffing levels. We asked to see the trust's tool for measuring staffing in the emergency department but this was not provided.
- There were also daily reviews of nurse staffing levels in the department which was captured on the trust's intranet that was available in the department. This allowed them to see whether they were staffed up to planned numbers or not.
- The trust had an ongoing recruitment drive. Some nurses had been recruited from Europe. Additional cover was also provided by agency staff and substantive staff working extra shifts.
- In order to cut down on the amount of agency staff used, the trust was incentivising its own staff to work additional shifts as bank staff in the department. These are temporary nursing staff who do not work for agencies but are directly employed by the trust as part of a nursing Bank.
- A registered children's nurse was not on duty on every nursing shift. Although there were two registered children's nurses employed in the department they were only able to cover for 48 hours a week. National guidance from the Royal College of Paediatrics and

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

- Out of these hours assistance was provided by registered children's nurses from the paediatric wards.
- There were also two emergency nurse practitioners who had undertaken specialist training in paediatrics.
- Emergency department nurses were undertaking the European Paediatric Advanced Life Support certificate. This was an ongoing programme of training and support.
- We reviewed the nursing rota for the period 14 September to 11 October 2015. The staff on duty were also recorded on a white board in the department that staff could refer to.
- The staffing was normally in the ratio of ten qualified nursing staff to two health care assistants, or nine qualified nursing staff to three health care assistants, during the day. Many staff would work long days of about 12 hours. There were eight qualified nurses and one health care assistant at night, with another health care assistant working a twilight shift to about midnight.
- Staff would cover all areas of the department, with specific staff rostered to work in the minors' area, whilst others would cover majors and resuscitation areas. There were also nursing staff who would cover the Single Point of Access, which was the management of patients who were sent to the emergency department by their GP's or the Out-of-Hours service.
- On 15 October 2015, as part of our inspection we observed an evening shift up to 9pm.There were nine qualified nurses and three health care assistants working up to 7.30pm. There was also another health care assistant who worked a twilight shift up to about midnight. Two of the qualified nurses were emergency nurse practitioners. In addition to these numbers there was also a registered children's nurse working from 9am to 9.30pm. From 7pm there were eight qualified nurses and one health care assistant working overnight. This shift finished at 7.30am except for one nurse who would finish at 5am.
- Out of these numbers there were two Band 5 qualified nurses who were from an external nursing agency, although they regularly worked in the department. There were also two Band 3 health care assistants who were working as part of the Bank. The Bank is the hospital's in-house agency.
- We found on inspection that the nursing staff were overstretched by the numbers of patients, many acutely ill, who were waiting to be seen. Of these patients eight were waiting for a bed on the medical wards. This was exacerbated by a lack of space in which to see patients. We found that two patients waited long periods of time in the ambulance handover area without being assessed by emergency department staff. We were also told there was not enough staff on duty to allow a nurse to be allocated to receiving ambulance patients and the expectation was that when ambulance patients arrived the ambulance crew would come round to the nurses' station to tell them they had brought in a patient. This was corroborated by our observations and by the ambulance crews we spoke with.
- Staff we spoke with told us they regularly worked on after their shift finished.
- We found that because of the shortage of qualified nurses agency nursing staff were used regularly. For the month of November the trust was intending to fill 24 shifts with agency staff.

Medical staffing

- We found the service was not staffed in line with nationally recommended levels of consultant cover, or to the trust's own levels. Staffing levels provided by the trust for July 2015 showed an establishment of 4.89 whole time equivalent (WTE) emergency department consultants. There were 1.89 WTE in post which left a variance against establishment of 3 WTE. The rotas showed there were two whole time equivalent locum consultants working in the department.
- There was also one whole time equivalent associate specialist working on the consultant rota. Associate specialists are senior middle grade doctors.
- This was confirmed by consultant staff who told us there were two substantive consultants, two locum consultants and an associate specialist who worked on the consultant rota.
- The Royal College of Emergency Medicine (RCEM) recommends there should be 10 whole time equivalent consultants as a minimum in every emergency department that had attendances of' between 50,000 and 80,000 patients a year. Scunthorpe emergency department treated 63,707 patients between April 2014 and March 2015.

- In information provided to us prior to the inspection the trust said that: "Consultant Hours present per day – 11 hours per day...".
- We reviewed 13 weeks of medical rotas for the emergency department that covered the period 2 November 2015 to 31 January 2016. We found that between Monday to Friday there was a consultant presence in the department for seven to 12 hours. However, on Saturdays and Sundays consultant presence in the department was only for three hours with on call cover at other times. There was also a reduced consultant presence in the department on bank holidays.
- The rota for the week commencing Monday 2 November 2015 showed 12 hours of consultant presence on the Monday, on the Tuesday this had reduced to seven hours, whilst on Wednesday to Friday the presence was for 11 hours. On Saturday and Sunday there was a consultant in the department for three hours on each of these days.
- For the rota for the week commencing Monday 9 November there was 12 hours consultant presence Monday to Friday. On Saturday and Sunday there was a consultant in the department for three hours on each of these days.
- The rotas showed that on 25 December there was no consultant presence in the department. Out of the four consultants (including locums) and one associate specialist on the rota one person was on-call whilst the others were marked as being on Bank Holiday. On the 28 December there was a consultant in the department for three hours. On 1 January 2016 there was a consultant in the department for eight hours.
- The other rotas we viewed showed similar consultant presence during the week with three hours covered each day of the weekend.
- Where there was more than one consultant on duty on the rota this was usually during the day from 9AM which left gaps in the rotas in the evening which were often the busiest periods.
- When we visited the department during a weekday in early November between 10am to 9pm there was a consultant in charge of the majors and resuscitation areas, supported by three middle grade doctors and two junior doctors. Similar numbers were on during a busy evening shift. Another consultant worked in the minors' area up to about 5pm.
- There was an establishment of seven WTE middle grade doctors with five WTE in post. There was an establishment for eight WTE junior doctors with five in post. The remaining three posts were covered by locum doctors, some of whom were long term locums. For the rota for the week commencing Monday 2 November 34 middle grade shifts out of 43 were covered by locum doctors. There was a similar ratio for the other 12 rotas we reviewed.
- Figures provided by the trust showed that 28% of all medical posts in the emergency department were vacant. This included consultants and junior doctors.
- Locum doctors, some of whom were employed on a long term basis, were used to cover vacancies at all levels within the department. The associate medical director told us there was a budget for locum doctors held by the department. They said they were intending to convert this budget into a substantive medical budget in order to recruit more doctors to substantive positions.
- The associate medical director told us that because of a shortage of emergency department doctors nationally they were recruiting consultant and middle grade doctors in the Indian subcontinent.
- We were told that six emergency nurse practitioners had been identified that would be trained to work as practitioners in the majors and resuscitation areas. This would take some of the workload pressures off the medical staff. However, this training had not started.
- There was no specially trained paediatric emergency medicine consultant in the department. However, this was not a national requirement if emergency departments see less than 16,000 children a year. The department saw less than that number of children.
- The general training for emergency medicine consultants does include training in paediatrics.
- We were told that when required paediatric medical assistance was provided by paediatric doctors working in the main hospital.

Major incident awareness and training

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

Urgent and emergency services

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

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated emergency and urgent care as 'good' for effectiveness because:

- Whilst the department had in place best practice guidelines including those produced by the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine not all had been implemented or audited. The results of the Royal College of Emergency Medicine 2014/15 audit of mental health in the emergency department were in the lower quartile of all trusts in England. There was no evidence of a re-audit of the department's sepsis screening tool since 2014, or a previous RCEM audit of sepsis.
- At the time of the inspection the percentage of nurses who had received appraisals was at 51%, against a trust target of 90%. Developmental training sessions were in place, although some elements of this training had only recently started. There had been no recent training of staff in the care and management of patients with a mental health condition.
- There were good systems of multidisciplinary working and there was a seven-day service available for patients, but not always supported by onsite ED consultant presence. Systems and process for the taking of consent and the management of the Mental Capacity Act were in place. There was also reasonable staff knowledge of consent procedures and the Act. Staff offered patients pain relief, food and drink.

Evidence-based care and treatment

- We found the emergency department (ED) had in place best practice guidelines in the care and treatment of patients. These included those developed by The National Institute of Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM).
- NICE and other guidelines were available on the trust intranet although in some cases these guidelines were out-of-date.
- We found there were protocols that had been developed for the emergency nurse practitioners. However, many of these had a review date of 2014.
- An audit of the trauma team activation had been undertaken. A report had been produced and an action plan was underway. This was aimed at improving the response times for the trauma team who were called down from the main hospital when a trauma case was admitted to the resuscitation area.
- Information provided by the trust said that other audits that were planned, but not commenced, included a medicine documentation audit, and an audit of fracture clinic referrals.
- The trust had taken part in RCEM audits. Clinical staff we spoke with were aware of the results and the action plans.
- We were told that the service also intended to review previous RCEM audits to ensure that there had been improvements.
- However, there was no evidence of an audit of the department's sepsis screening tool since 2014, or a previous RCEM audit of sepsis. In the 2013/14 RCEM audit of sepsis the department had not met the standards regarding when the received antibiotics.

Pain relief

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

Nutrition and hydration

- In the 2014 patient survey of the trust's two emergency departments, the trust performed about the same as other trusts for patients being able to access suitable food and drink. This resulted in a score of 5.7 out of 10.
- Water was made available for patients and there was a vending machine in the waiting area.
- Healthcare assistants were allocated on a daily basis to attend to the nutrition and hydration needs of patients.

Patient outcomes

- In a Royal College of Emergency Medicine (RCEM) 2014/15 audit of mental health provision Scunthorpe ED scored worse for one of the fundamental standards and met the other. The audit found that the emergency department did not have a: "Dedicated assessment room for mental health patients." This ED also scored worse for five of the six developmental standards. These standards were: "History of patient's previous mental health issues taken and recorded; Mental state examination taken and recorded; Provisional diagnosis documented; Assessed by mental health practitioner within one hour; and details of any referral or follow-up arrangements documented."
- In the Severe Sepsis audit 2014 Scunthorpe ED scored in the upper quartile for three of the 12 indicators and in the lower quartile for three.
- In an RCEM audit of 2014/15 into the initial management of the fitting child the Scunthorpe ED scored in the upper England quartile for the fundamental standard and scored in the lower England quartile for two of the four developmental standards.
- In the April 2013 – December 2014 Trauma Audit and Research Network (TARN) report it was found that the outcomes for trauma patients had improved in comparison with the 2012/13 audit.
- We also reviewed an initiation document for a planned audit of trauma team call-outs that was to be undertaken in November 2015.

Competent staff

- The senior nurse for the emergency department told us that the percentage of nurses who had received appraisals was at 51%, against a trust target of 90%. They told us they had changed the timing of when they did appraisals which would allow them to improve the percentage of staff that had an appraisal within the year.
- The appraisal rates we received from the trust were for the directorate of medicine at Scunthorpe and Goole hospitals, of which the emergency department was a part. They showed that 82% of medical staff and 72% of administration and clerical staff had received appraisals.
- Training sessions that involved other departments, including the intensive therapy unit and the clinical decisions unit, had been arranged and were displayed on a board in the senior nurse's office.
- Staff had not received specialist training in mental health. The senior nurse for the department, and other nursing staff, told us that there had been no recent mental health awareness training. However, they told us they were in the process of addressing this by organising training courses.
- Other training days for all grades of staff had recently commenced in the department. We saw an attendance register for various teaching sessions led by a senior consultant.
- We found there healthcare assistants were offered advanced skills training so that they could put cannulas into patients and put on plaster casts.
- Clinical and managerial supervision was provided for staff.

Multidisciplinary working

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

Seven-day services

- The emergency department offered a seven-day service with consultants available on-call when they were not in the department. However, there was only three hours per day consultant presence in the department at weekends.

Urgent and emergency services

- There was 24 hour access to the x-ray department which was located next to the emergency department.
- There was portering cover provided seven days a week.
- The April 2013 – December 2014 Trauma Audit and Research Network (TARN) report it found that the median time for the wait for a CT (computed tomography) scan was two hour and 10 minutes, which was an improvement on the 2012/13 results.
- There was seven day access to a mental health crisis team although they were not based in the department and could take up to two hours to arrive. The Royal College of Emergency Medicine recommendation is that a mental health act practitioner should be available within one hour.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood the principles of consent including the Gillick Competency guidelines, which relate to the obtaining of consent from children and young people.
- We were informed by an emergency department consultant that patients requiring sedation before undergoing procedures in the department provided written consent.
- We observed clinical staff obtaining verbal consent, from both adults and children, before undertaking procedures. This would often take the form of them explaining the procedure to patients and recording their agreement in the patient record.
- The majority of staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- A form was available to be completed by clinical staff when assessing patients' mental capacity.
- Records for the directorate of medicine at Scunthorpe and Goole hospitals, of which the emergency department was a part, showed that 89% of nursing staff had undertaken Deprivation of Liberty Safeguards level one training, against a trust target of 95%. The attainment for medical staff was at 95% whilst for administrative and clerical staff it was 100%.
- Trust records for the emergency centre showed that 27% of medical staff had undertaken Mental Capacity Act training, whilst 86% of nursing staff had taken the training.
- These figures were below the trust target that 95% of staff should have received this training.

Are urgent and emergency services caring?

When we inspected Urgent and Emergency Care in April 2014, we rated it as good for caring and therefore this domain was not inspected during this inspection.

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

(for example, to feedback?)

Requires improvement

We rated emergency and urgent care as 'requires improvement' for responsive because:

- There had been little change since our last inspection in April 2014.
- The emergency department failed to meet the needs of mental health patients, with patients having to wait in unsuitable accommodation that was unsafe. Not all staff were aware of how to contact professionals to help communicate with people who may be deaf or unable to understand/speak English.
- There were breaches to the national standard of within 30 minutes for patients being handed over by ambulance staff to the emergency department team, with some waited over one hour. Between April 2015 and October 2015 a total of 2,212 patients (21.4%) waited more than 30 minutes. Over the same period 422 patients waited over one hour before handover.

- Between April 2015 and November 2015 the national standard to achieve 95% of patients being seen and a decision made to treat, discharge or admit within four hours ranged from approximately 93% to almost 96% across all sites.
- Staff we spoke with gave a mixed picture of learning from complaints with some staff saying they were informed of the learning whilst others, particularly junior staff, told us they were not.
- There was a flow coordinator in place to improve the patient journey through the department.

Service planning and delivery to meet the needs of local people

- Since April 2014 monthly attendance figures have remained steady with between 5,000 and 5,500 patients attending each month.
- Since our previous visit in April 2014 the trust had created three new treatment rooms out of doctors' offices, made changes to the children's waiting area and relocated the relatives' waiting room. They had also developed a new waiting area for patients still under the care of ambulance crews.
- Since 2014 they had also negotiated with the stroke department so that stroke patients were not routinely taken to the resuscitation room on arrival. They were now only treated there if they required thrombolysis.
- The trust were in the process of working with the ambulance service so that an electronic monitoring system could be provided that would be able to accurately monitor the turnaround times for ambulances.

Meeting people's individual needs

- We found there was limited support for patients with a mental health condition when the department was busy. We were told that if a person at risk was identified staff would sit with them in a treatment room until the mental health crisis team arrived. The crisis team was not based in the hospital and could take about two hours to arrive.
- As was identified under the Safe domain above there were no suitable rooms for the care and treatment of psychiatric patients.
- We visited the department during the evening when it was busy and observed that an at-risk mental health patient was left in the waiting room by staff as no rooms were available. It was also not possible for a member of staff to be freed up to sit with the patient. This led to the patient's privacy and dignity being compromised as they were left in a busy waiting area. After we brought this to the attention of the nurse in charge they told us they would contact the site manager for help, and ask a member of the security staff to sit with the patient. Although the members of the security team were experienced they did not have special training in the observation of people with mental health conditions. It was also the case they were easily identifiable as security staff as they wore police type uniforms. Therefore their presence in the waiting room sitting next to a patient could cause embarrassment and compromise their dignity.
- There was also no evidence of risk assessments being undertaken to ensure that optimum systems for the care and treatment of mental health patients were in place. However, a scoring information system used to assess patients who may have been suffering from depression was used. We were told that changes had been made to the original to make it more useful in the emergency department.
- We brought our concerns to the trust. Following the inspection the trust told us they had developed a "mental health assessment in self-harm patients' tool" in conjunction with the lead consultant psychiatrist from the local mental health trust. They also told us that staff would be made available to sit with mental health patients when required in the interests of safety.
- Interpreting services were available for people whose first language was not English. Due to the emergency nature of the emergency department this was normally provided by professional staff over the telephone. However, a member of staff we spoke with told us they would use relatives to help translate. The use of relatives and friends to help translate could compromise patient privacy, and may lead to the mistranslation of important clinical information.
- There were systems in place for providing professional sign language support for patients who were profoundly deaf and communicated through British Sign Language (BSL). We were informed that the trust had arrangements in place that allowed them to contact sign language interpreters at short notice. However, not all staff we spoke with were aware of this system, and there were no electronic interpretation solutions for when interpreters could not be contacted.

- There was a room for the family or friends of people who were critically ill or had recently died to go to. This room and the nearby viewing room were located away from the resuscitation room in a quieter area of the department. The room had arm chairs, a telephone and facilities for refreshments. Leaflets providing information about support services were available and could be sourced in non-English languages.
- The needs of people of faith were met by a multi-faith team in the hospital, which was contactable on a 24 hour basis throughout the year. This team could obtain support from representatives of the different religious faiths.
- If staff wanted to access patient advice leaflets, departmental, specialty or NICE guidance and protocols they could do so through the trust intranet.
- Patient advice leaflets were available in non-English languages.

Access and flow

- Between April 2015 and November 2015 the national standard to achieve 95% of patients being seen and a decision made to treat, discharge or admit within four hours ranged from approximately 93% to almost 96% across all sites. The trust was at or above the standard in June, July and September 2015.
- Between April and September 2015 a total of 8,353 patients (25.4%) were admitted to the hospital, whilst 839 were transferred to another healthcare provider.
- The trust provided us with data that was produced by the ambulance service. This recorded the time patients waited before being handed over from the ambulance crew to emergency department staff. The national standard is that this should occur in less than 30 minutes. Black breaches occur where handovers from ambulance arrival to the patient being handed over to ED staff take longer than 60 minutes.
- This data showed that between April 2015 and October 2015 a total of 2,212 patients (21.4%) waited more than 30 minutes. Over the same period 422 patients waited over one hour before handover. In October, the month of our inspection 78 patients waited between one and two hours to be handed over, whilst three waited over two hours.
- Ambulance crews told us that they had experienced extended waits to hand over patients. They said short handovers were completed on arrival and full handovers once the patient was transferred to the emergency department team. They recounted occasions when they had continued to treat patients whilst they were on ambulance trolleys in the corridor.
- During our observations of a busy evening shift that patients waited longer than 30 minutes before handover.
- There was no electronic system that allowed joint handover times to be recorded. Electronic handover systems prevent situations where the records of trusts and ambulance services differed leading to disputes about the times. The trust and the ambulance service were in the process of putting in place an electronic handover system. However, it was not in operation when we visited the department.
- There were electronic systems to monitor access and flow in the emergency department.
- There was a flow coordinator who was responsible for tracking patients as they made their journey through the department. The co-ordinator contacted specialty teams and support services to improve patient flow through the department. They also worked with the bed and site managers were identify empty bed space on the wards.
- A system was also in place that when it was not possible for the specialty teams to see a patient in good time, but there was a bed available, the emergency department consultants were able to send the patient to the relevant ward.
- Patients we spoke with told us they had experienced long waits for treatment and that this was their main area of concern.
- Between April and September 2015 a total of 690 patients (2.1%) left the department without being treated. A total of 179 patients left the department having refused treatment.

Learning from complaints and concerns

- There was evidence from unplanned care and governance minutes that the lessons from complaints were shared. We were also told that they were discussed at the huddles that took place during a nursing shift change.
- There was also a complaints' file that contained 50 cases. There was evidence of a discussion of learning from these cases. One particular case involved a complaint from the family of a patient that had

attended with a mental health condition. An action point from the learning which arose from this case was that greater levels of mental health training should be provided to staff. However, this had not occurred.
- Staff we spoke with gave a mixed picture of learning from complaints with some staff saying they were informed of the learning whilst others, particularly junior staff, told us they were not.
- As with other areas related to the provision of information, the assistant medical director had introduced a system where staff were encouraged to ask about any issues of concern.

Are urgent and emergency services well-led?

Inadequate

We rated emergency and urgent care as 'inadequate' for well-led because:

- There had been no significant improvement since our last inspection in April 2014. There was no vision or strategy specifically for emergency care.
- We found that since our last visit the emergency department leadership was still in a period of change. Although some work had been undertaken to improve the environment of the department there was still substantial work that required to be done. There had been a failure since our inspection of April 2014 to improve the facilities and responsiveness towards the safety and well-being of people who attended the department with a mental health condition. Following the unannounced inspection in November 2015 the trust did initiate changes.
- Governance was inadequate. Whilst there were trust-wide governance and risk management systems in place down to directorate level they were not operating effectively within the department or its directorate. None of the risks highlighted by the inspection team had been identified on either the directorate risk register or the trust's corporate risk register.
- The department took part in national and local audits, however, these were not always acted upon in a timely manner.
- There was a new management structure in place. Staff told us there was a disconnection between themselves and the other trust emergency department at Grimsby, however, they were satisfied with the local leadership.

Vision and strategy for this service

- Staff we spoke with were aware of the trust's vision and strategy.
- Staff we spoke with were not aware of any stated values and vision espoused by leaders within the emergency department. However, there was a desire to put the patient at the centre of what they were doing on a daily basis.

Governance, risk management and quality measurement

- Whilst there were trust-wide governance and risk management systems in place down to directorate level they were not operating effectively within the department or its directorate.
- Governance, risk management and quality measurement were included as items in the unplanned care business and governance meetings for the directorate of medicine which included emergency care. These meetings fed upwards through the trust's systems of clinical and corporate governance.
- However, none of the risks highlighted by the inspection team had been identified on either the directorate risk register or the trust'strust's corporate risk register. These risks included medical and nursing vacancies, gaps in the consultant rota, care and safety of patients with mental health needs and treatment rooms created that did not meet required specifications.
- Although since the previous inspection doctors rooms had been turned into patient treatment rooms there had been no risk assessments completed against national standards to allow for the safe evacuation of trolley patients in an emergency.
- There was one item of risk for the emergency department on the trust risk register, which was whether they would be able to meet the contractual performance targets, such as the four hour wait standard for 2015/16. There were no items on the medicine/emergency department risk register.
- We were told that information from these meetings fed down to staff working in the departments through the

huddles that took place at nursing shift handovers and meetings that had been recently organised by the assistant director of medicine. We saw these 'huddles' taking place

- The department took part in national and local audits, for example, Royal College of Emergency Medicine and the Trauma Audit Research Network audits. However, these were not always acted upon in a timely manner, for example the Royal College of Emergency Medicine (RCEM) audit of 2014/15 into mental health. There was no evidence of an audit of the department's sepsis screening tool since 2014, or a previous RCEM audit of sepsis. In the 2013/14 RCEM audit of sepsis the department had not met the standards regarding when the received antibiotics.
- The trust initially told us they did not have information on the initial assessment of patients arriving by ambulance or ambulance handover times on a hospital location basis. This was only available on a trust wide basis. In order to analyse performance effectively it is necessary to collect data that related specifically to each emergency department. The information initially provided was based on three emergency departments combined, one of which was a minor injuries unit. Including a minor injuries unit would improve the overall picture presented as the unit does not accept seriously ill patients or the victims of major trauma conveyed by ambulance.
- The trust later provided information on assessment and handover times that was produced by the local ambulance service trust. They stated that this data had not been validated. If the trust were relying on this data to improve their services they would need to analyse and validate it.

Leadership of service

- The emergency department at Scunthorpe was part of the medical directorate which included the other emergency department at Grimsby and the minor injuries unit at Goole. The leadership of the directorate consisted of a triumvirate, composed of an assistant medical director, who was also the lead emergency department consultant, a matron, and an associate chief operating officer. This allowed for the representation of the two main clinical groups with a link to the trust's corporate management structure through the associate chief operating officer. These changes had occurred since the last inspection.
- The nursing leadership in the department had recently changed with a senior nurse from Grimsby appointed to oversee the Scunthorpe ED.
- Staff of all grades that we spoke with were satisfied with the clinical leadership provided in the department. However, they felt a disconnection between themselves and the other trust emergency department at Grimsby.
- Since our inspection in April 2014 the leadership had failed to improve the facilities for patients who attended with a mental health condition. Although the trust did respond after we brought our concerns to their attention during the 2015 inspection.
- Senior clinical leadership was problematic as there was not enough substantive consultants in post to lead the effectively lead service.
- At the previous inspection senior staff had told us that they were developing emergency nurse practitioners to work in the majors' area in order to take some of the workload pressure off emergency department medical staff. This had not been implemented by the leadership. During this inspection we were told by senior managers that this was still there intention, although no emergency nurse practitioners were working in this role.

Culture within the service

- We found a culture which saw the emergency department as being a separate entity from the emergency department at Grimsby. Although this was something the trust was trying to change with the employment of a senior nurse at Scunthorpe, who had previously managed the department at Grimsby. The assistant medical director also attended both departments, as well as the minor injuries unit at Goole.

Public engagement

- The trust took part in the 2014 accident and emergency survey of patients. This was organised on a trust wide basis and included the emergency departments at Grimsby and Scunthorpe.
- Apart from the above and the friends and family test surveys that were carried out in the department there was no evidence of public involvement.
- There was no evidence of public engagement with work that had been undertaken to convert doctors' offices into clinical rooms. There was also no evidence of public engagement in the plans that the associate director told us were being developed to improve access to the department and expand the children's waiting area.

Urgent and emergency services

Staff engagement

- There were meetings that could be attended by all staff in the department and the assistant medical director had started a policy they described as: "If you don't know ask". This involved encouraging staff to ask senior staff if they had any concerns or any issues they required information about.
- We found that the meetings held with staff were for the provision of information and education. We reviewed signed attendance records and notes from these meetings.
- However, the majority of the non-managerial staff we spoke with felt that communication around the plans to refurbish the department had been poor. They told us they were aware there was work going to be carried out to redesign the department, however they were not sure what form this work was going to take.
- Staff who told us they were aware of the changes said they had been asked their opinion, although not all of them were confident it had been taken into consideration.
- The impression given was a mixed picture with some staff feeling well involved whilst others felt alienated from the process.

Innovation, improvement and sustainability

- There had been improvements since the previous inspection with the development of a pleasant and relaxed relatives' waiting room away from the resuscitation area.
- Improvements had been made in the resuscitation room with all the bays now available at all times for the treatment of emergency department patients.
- There had also been an increase in the number of patient treatment rooms and the development of a new waiting area for ambulance patients.
- However, there had not been substantial changes made to improve the facilities for children and young people. Although there were plans to expand this provision.
- Although there were long term plans for major alterations to the department to provide separate entrances for minor patients, GP referrals and seriously ill patients coming in by ambulance, the evidence showed these were still at an early stage of development.

Medical care (including older people's care)

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

Information about the service

Scunthorpe General Hospital has seven medical wards plus specialist units such as a coronary care unit, a specialist stroke unit, a clinical decisions unit and a planned investigation unit. The medical directorate has within it a number of different specialties including general medicine, care of the elderly, cardiology, respiratory medicine, diabetology, gastroenterology and stroke care.

Between January 2014 and December 2014 there were approximately 44,900 medical episodes of care carried out in the trust with 22,600 carried out on the Scunthorpe General Hospital site. Day cases accounted for 64% of all episodes with emergency admissions 26% and elective admissions 10%.

At the last announced comprehensive CQC inspection in July 2014, we rated the service for medicine overall as requires improvement. Caring was good, but the service required improvement for being safe, effective, responsive and well led.

During this inspection, we spoke with 24 patients and their relatives, and 49 staff, including doctors, nurses (two of whom were agency nurses), student nurses, health care assistants, therapists, ward managers, matrons, housekeepers and administrative assistants. We also looked at the records of 21 patients. We visited 77 wards, the stroke unit, the cardiac care unit, the planned investigation unit and the clinical decisions unit. We also visited the endoscopy unit. We attended a number of focus groups and we observed care being delivered on the wards we visited. Before the inspection, we reviewed performance information from and about the trust.

Medical care (including older people's care)

Summary of findings

We rated medical services as 'requires improvement' overall. Safe and responsive were rated as 'requires improvement'. Effective, caring and well-led were rated as 'good'.

- Staffing levels were often below the minimum agreed level required to provide safe care. We saw occurrences when there were only one registered nurse and two health care assistants on a ward overnight to look after 28 patients. Although managers were trying to minimise risk to patients we heard call bells left unanswered for 10 minutes and a patient told us there had been a delay in receiving pain relief because nurses were so busy.
- Feedback and learning from incidents was not consistent across the hospital, with many staff saying they did not receive any feedback.
- Medicines were mostly well managed but there was an issue with the monitoring of fridge temperatures on most wards.
- Some issues negatively affected patient access and flow.There were issues with flow through the hospital with Ward 2 (Short Stay Ward) and the clinical decisions unit often being unable to move patients to the most appropriate ward. It was reported that it was often difficult to re-patriate stroke patients back to their local hospitals due to bed capacity problems.
- Mandatory training levels had improved for nursing staff. However, training levels for medical staff fell significantly below the trust target.
- Quality audits were completed every month on each ward and any areas of concern were addressed with an action plan. The trust participated in national clinical audits scoring well in the Stroke Sentinel National Audit Programme, with an overall score of B.
- There was improvement in the number of medical and nursing staff who had a managerial appraisal of their work performance.
- Patients received compassionate care and were treated with dignity and respect. Their privacy was preserved. Patients and relatives we spoke with felt very happy about how they were looked after and said staff were kind, caring and patient.
- Since July 2014, referral to treatment time in this trust has been above the 90% standard in all specialties measured.
- The wards we visited appeared well organised and managed. Action had been taken on wards that had been previously failing, which had led to improvements. Staff spoke well of their line managers and found them to be supportive.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated medical care as 'requires improvement' for safe because:

- On many occasions, the number of nursing staff on duty was below the minimum agreed level in order to provide safe care. We saw occurrences when there were only one registered nurse and two health care assistants on a ward overnight to look after 28 patients. Although managers were trying to minimise risk to patients we heard call bells left unanswered for 10 minutes and a patient told us there had been a delay in receiving pain relief because nurses were so busy.
- There was minimal medical cover at night with one registrar and two junior doctors covering the stroke unit, the clinical decisions unit and all medical wards. A consultant on call supported them. During the unannounced inspection, there was evidence of delayed treatment and care due to the high workload of the junior doctor who was unable to see all patients on the wards in a timely manner.
- Staff followed systems to report incidents of harm or risk of harm but feedback and learning from incidents was not consistent across the hospital, with many staff saying they did not receive any feedback. Incidents should be investigated and the lessons learned shared with staff to help prevent them happening again.
- Medicines were mostly well managed but there was an issue with the recording of fridge temperatures on most wards.

However;

- We observed day to night-time nursing handovers on three wards and found them systematic and thorough. The medical handovers we observed were highly organised, well structured and an example of good practice.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were no never events reported by the directorate of medicine between August 2014 and July 2015.
- Serious incidents are incidents that require further investigation and reporting. For the directorate of medicine across all sites, 27 serious incidents were reported between August 2014 and July 2015; 12 were pressure ulcers and seven were unexpected deaths.
- A matron said the service had an open culture of incident reporting and that feedback was shared with staff verbally. However, we asked two doctors, four nurses and three health care assistants if they received feedback from incidents and all told us that they did not receive any.
- A ward manager told us she was creating a newsletter to share learning from incidents. She showed us how she monitored which staff had read the newsletter by using a signature sheet. For significant issues, each member of staff was given an individual copy and asked to sign to say they had received it.
- Staff we spoke to were aware of how to report incidents and told us they did this using an online electronic system. They were able to tick a box on the form to request personal feedback but said they very rarely received any.
- We saw an incident trigger list displayed on Ward 24 giving details of what was classed as an adverse incident and needed reporting.
- The trust had launched a campaign called ASK to encourage staff to seek feedback from incidents but none of the staff we spoke to were aware of the ASK campaign.
- Monthly mortality and morbidity meetings were held for stroke, cardiology, and gastroenterology. We saw in the minutes of these meetings that information was fed into the Mortality Performance and Assurance Committee. We also saw action plans to improve mortality and morbidity for stroke, cardiology and gastroenterology.

Duty of Candour

- The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate, truthful information from health providers.
- The staff we spoke to demonstrated a good awareness of the duty of candour. A matron told us the duty of candour was embedded in the organisation and she gave an example of sharing the outcome of an incident investigation openly with a patient and their family.

Medical care (including older people's care)

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), and catheter-related urinary tract infections (CUTIs). Between July 2014 and July 2015 there were 129 pressure ulcers, 42 falls with harm and 29 CUTIs in the directorate of medicine, with most of these occurring within the first six months.
- Information on patient falls and pressure ulcers was on display on most of the wards we visited. The clinical decisions unit reported no falls in the month of August.

Cleanliness, infection control and hygiene

- The wards we visited were mostly clean without clutter. We observed a great deal of cleaning activity on wards during the inspection that patients said was unusual. The exception was Ward 16, where we observed a cluttered environment with dust on some equipment and a commode in a sluice room with faeces visible on the seat. We also saw a housekeeper enter an isolation room with a meal tray and not change their apron or wash their hands on exit. We reported this to the ward manager at the time.
- Personal protective equipment including aprons and gloves, and alcohol hand gel were available at the entrance to and throughout the wards we visited. Waste and linen was appropriately segregated and disposed of correctly on most occasions. However, we saw an occupational therapist carrying wet towels from a bathroom to the sluice without wearing any personal protective equipment.
- A ward cleanliness poster and infection prevention and control information was on display on the noticeboard on Ward 24. The patients we spoke with were happy with the level of cleanliness on the wards. One patient on Ward 24 said it was spotless. However, on wards 16 and 24 we saw patients who were being barrier nursed in side rooms and although there was a standard isolation sign on the door, the door was left open. We asked why and were told that staff needed to keep an eye on the patients as they were at risk of falling.
- Before and during the inspection we received several concerns and a complaint regarding the cleanliness and care on ward 23. When we visited this area, it had recently been cleaned and we did not find anything of concern. Most patients we spoke with on the ward said that it was normally clean but they were seeing extra cleaning that day. One patient was unhappy with the level of cleanliness on the ward.
- Most staff we observed during the inspection followed the uniform policy and had clear name badges. The uniform policy was not followed by some staff on Ward 16, who were wearing jewellery.
- We noticed on the stroke unit that there were no changing facilities for health professionals and we were told that there were none in the whole hospital. Staff came to and from work in their uniforms and there was a policy to cover this. We checked the policy, which stated that apart from some specific staff groups (for example, staff working in the mortuary) this was acceptable as long as uniforms were covered with a long coat.
- We saw a certificate on the noticeboard of Ward 18 congratulating the ward on 900 days free from infection.
- The level of infection control training for the directorate of medicine was 76% for nursing staff against a trust target of 95%. Medical staff had achieved 100% compliance.
- We looked at the results of the patient–led assessments of the care environment (PLACE). The hospital achieved a cleanliness score of 96.58 % in 2015 against the national average of 97.57%.
- We saw that Clostridium Difficile and MRSA audits were completed between January 2015 and July 2015. For those areas not scoring 100%, there was a plan for issues to be dealt with by the chief nurse. Immediate feedback of audit results was to be given to ward sisters by the infection control and prevention nurses. Staff told us that extra observations and training had been implemented where this was found necessary.
- Hand hygiene was audited monthly. Results showed that from January 2015 to July 2015 medical wards at the hospital showed 100% compliance. However, we observed handwashing practice on the stroke unit and found that a number of times handwashing did not take place when it should have.
- Domestic staff had a clear understanding of their duties in relation to isolation practice, deep cleaning and legionella precautions, such as water flushing. Water flushing was recorded as being undertaken.

Environment and equipment

- Resuscitation equipment was available on every ward and weekly checks had been completed.
- The equipment we inspected on ward 2, 23 and 24 appeared clean and was clearly labelled with the date it had last been cleaned. There were some items of dirty equipment observed on the stroke unit.
- We saw that the electronic equipment had been tested for electrical safety within the last twelve months and had testing appliance labels attached.
- The endoscopy unit appeared cluttered and had two drying cabinets stored in the corridor. We were told that a new unit is currently being built and the service will be moving into the new facility within the next year.
- A new decontamination unit was scheduled to be open in the next 2 weeks, which should improve the standard of decontamination for endoscopy equipment, which is currently not fully compliant with standards.
- The stroke unit was generally in a good state of maintenance and repair; however, we observed that the sink in the clinical unit had been leaking intermittently over a long period. There was evidence of long standing water damage on the surrounding bench area. The ward sister told us this had been reported a number of times and also escalated to the matron and senior nurse approximately two months ago but the damaged bench was not yet scheduled for repair or replacement.
- The catheterization laboratory (cath lab) operated in a shared facility with the pain clinic and other diagnostic procedures. It appeared cramped and chaotic. The area was cluttered with storage boxes in the corridors. The lab was also quite a distance from the planned investigation unit where most patients came from.

Medicines

- We saw that medicines were stored appropriately and securely in locked cabinets in a locked treatment room. IV fluids were stored securely and stock rotated. All patients own drugs were stored in locker at their bedside.
- The drugs fridge was locked and there was a method in place to record daily fridge temperatures however, we noticed that on Ward 24 the fridge temperatures were not recorded for 3 days in October and that minimum and maximum temperatures were not recorded on any of the wards we visited.
- The fridges on the stroke unit, clinical decision unit and Ward 24 were checked daily but only the current temperature was recorded. Staff were not aware of how to record minimum and maximum temperatures, what the recommended range was or that this was necessary for safety and efficacy of drugs. There was no clarity as to what action should be taken if the temperature was outside the range of 2C-8C. We saw several examples were a temperature had been recorded outside of recommended range but no action had been taken.
- On the stroke unit, we found parenteral feed out of date. Staff informed pharmacy to action removal / replacement when this was brought to their attention.
- Pharmacy staff visited the stroke unit daily, seven days a week to perform medicines reconciliation. They also performed a weekly stock check of the drugs cupboard and ordering of stock.
- We found that completion of medicines reconciliation and venous thromboembolism (VTE) risk assessments was good.
- The medicine charts we looked at all had clinical indications for antibiotics, review and stop dates were documented where appropriate.
- We saw that there was a good approach to the issue of availability of medicines keys on wards with the introduction of an electronic key system. Staff could hold their own key, which meant that access to medicines was safe and timely.
- Controlled drugs were stored correctly. We did not have any concerns regarding the recording and administration of controlled drugs.
- We looked at 14 medicine charts. Gaps noted on medicine charts were reasons for omission of dose; not recorded in four cases and oxygen prescriptions were incomplete or missing prescriber's signature in two out of five instances.
- We observed a poster at the nurse's station on Ward 24 with information about how to reduce the risk of omitted and delayed doses of medicine. There was also a medicines code poster on the notice board in the corridor.
- Patients we spoke to were happy with the way their medication was administered by the nursing staff. They said it was locked away and was given on time. A patient on Ward 22 was self-administering his medication and was happy with this as he felt he had control and knew exactly what he was doing.
- During an unannounced visit on 6th November 2015, we found that with the exception of Ward 16, fridge temperatures were still not being checked correctly. The minimum and maximum temperatures were still not

being recorded and we found out of date antibiotics in one fridge. On Ward 23, we found that the temperature of the drugs fridge was too high and records indicated that it had been operating at that level for the previous two to three months. Records indicated that medications within the fridges were not always routinely checked. We found one medication out of date. The staff we spoke to did not know what the correct temperature should be.

Records

- We looked at seven sets of medical records, which were overall completed to a good standard. We found that they were clear, concise and contemporaneous. All records had been signed and dated and most included completed risk assessments and appropriate actions that had been taken. Gaps in medical records included one illegible signature.
- Nursing records on Ward 16 were kept in worn folders in a plastic box in the ward manager's office. They were correctly dated and signed but did not always demonstrate that an action had occurred in response to a problem.
- Records we looked at on the stroke unit had clear, focussed and individualised care plans. Multidisciplinary pathways were used and goals were updated every day.

Safeguarding

- There was a dedicated lead for safeguarding and staff were aware of this. Staff we spoke with were able to give an example of a recent safeguarding issue and how this had been managed.
- Nursing staff on Ward 22 were able to give an example of a recent referral they made to safeguarding as they had concerns about the relative of a patient.
- Staff were clear how to escalate safeguarding concerns and had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Training records provided by the trust for medicine at Scunthorpe and Goole showed 94% of nursing staff and 44% of medical and dental staff had completed this training.
- For safeguarding children level one, completion rates were 100 % for nursing staff and 44% for medical and dental staff.

Mandatory training

- Information provided to us by the trust showed that overall, mandatory training compliance was 79% for medicine at Scunthorpe Hospital. For nursing staff rates varied across wards from 73% to 96%. Compliance with mandatory training for staff on ward 23 was 81%
- Medical staff compliance with mandatory training was poor with an average of 45%. In some teams, compliance was as low as 22%.
- Health care assistants told us they often accessed e-learning at home in their own time, as it was difficult to access a computer at work.

Assessing and responding to patient risk

- We observed the use of an electronic system called WebV to manage and monitor patients. We saw nursing staff measuring observations at patient's bedside and entering them onto an electronic device. 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. Web V incorporated a range of icons, which made it easy for health professionals to see risks associated with each patient. For example,, if a patient hadhad dementia or if they were at high risk of fallingfalling. It was easy to see at a glance whether any risk assessments were incomplete.
- Staff told us that when a patient was scoring five or above on the Web V system they would escalate the patient to medical staff on the ward, or contact the on call doctors. They would also increase monitoring to a minimum of hourly.
- During medical handover in the operational room, we saw medical staff using the data from WebV to discuss and prioritise patients. Doctors looked at a screen that showed every bed on each medical ward alongside the patients WebV score. This allowed doctors to identify patients at risk of deteriorating.
- There waswas no high dependency unit at Scunthorpe General Hospital although some of the doctors we spoke to said they thought it was needed.

Nursing staffing

- There were widespread issues with staff shortages.
- The service had been through a process of determining registered nurse staffing levels for each ward based on national guidance.

Medical care (including older people's care)

- Vacancy levels for qualified nurses were high. Figures provided by the trust for 31st July 2015 ranged from 19.51% to 39.30% on most medical wards. The coronary care unit was the exception with a vacancy rate of 3.7%. Minutes of the board meeting indicated that the trust were actively seeking to fill these vacancies and were pursuing an international recruitment campaign. The minutes also showed that the trust had been through a process of identifying staffing levels using a recognised staffing tool.
- Based on information provided by the trust the turnover rate for nursing staff on medical wards at SGH was 25.23% and the sickness rate was 5.07% for the last financial year.
- We were told that some wards had agreed minimum levels of staffing because it was not possible to achieve the planned level. The minimum level included an additional HCA to compensate for a reduction in a registered nurse.
- It was clear that ward mangers and matrons were working hard to manage staffing risks. Ward sisters tried to cover vacant shifts first with their own staff, then with bank or agency. However, wards were not always able to fill vacant shifts. In order to reduce risk to patients, some wards had been allocated additional support staff. Operational matrons met every day at 12pm to discuss staffing in order to maintain safe staffing levels. They would sometimes move staff across to cover wards were staffing levels were particularly low.
- Ward 24 was a 30 bedded ward. The minimum staffing levels for this ward were four registered nurses and four health care assistants in the day and two registered nurses and three health care assistants at night. On the day of inspection, the actual staff numbers were three registered nurses and three health care assistants during the day. This meant that during the day there was a nurse to patient ratio of 1 to 10. We looked at staffing rotas and saw that the minimum level of staffing had only been achieved on three days in the last month. The nurse in charge of the ward was included in these numbers. Staffing rotas for Ward 23 showed that in the last month minimum staffing levels had not been achieved for 17 days. Nurse staffing rotas on Ward 16 for August, September and October showed that on 27 days staffing levels were lower than planned levels. On two occasions, there was only one registered nurse and two health care assistants on duty at night to care for 28 patients.
- When we visited Ward 16 at 1.40pm, we found that the ward manager and one student nurse were the only nursing staff on the ward. We were told that the other staff were having lunch. During this period, a call bell went unanswered for at least 5 minutes. On a subsequent visit, we heard call bells ringing for 10 minutes before they were answered. Staff were caring however, they appeared to be able to spend little time with patients due to staffing levels and dependency of patients.
- The clinical decisions unit had 10 vacancies for nursing staff. They used bank and agency staff to cover where possible. We were told that some agency nurses were not suitable to work on the unit and this had been fed back to the agency to ensure that only suitable staff were supplied. The ward manager and deputy ward manager had both covered night shifts when short staffed.
- On the day we visited the clinical decision unit (22 beds) planned staffing levels were five registered nurses and three HCAs during the day and four nurses and two HCAs for the night shift. The actual staffing was five nurses and two HCAs during the day and three nurses and two HCAs for the night shift. There was a shortfall in staffing of one HCA during the day and one nurse during the night. At our unannounced visit on the 5 January 2016, there were four registered nurses on duty however only one was a permanent member of staff on this ward. This was the same on the 4 January 2016 and there were still gaps on the rota for the 6 January 2016; there was one ward nurse and one agency with two posts not yet filled.
- During an unannounced inspection on 5 January 2016, we saw on the staff rotas for Ward 23 that band 4 staff had been counted in the nursing numbers. This was concerning as the band 4 staff were newly qualified nurses awaiting their professional registration. These staff needed extra supervision and could not carry out tasks, such as administering medicines, which placed extra responsibilities on the existing nurses. We were made aware that a memo had been circulated to matrons since the October inspection, advising managers not to roster newly qualified nurses awaiting their registration as registered nurses if less than two substantive qualified nurses were on duty.

Medical care (including older people's care)

- We saw that the staffing rosters for Ward 18 had been prepared eight weeks in advance, however we were told they had problems filling empty shifts due to speciality of the ward and the need for specialist skills.
- Two doctors we spoke to were concerned about the nurse staffing levels on some wards especially at night.
- We were told that in the main the stroke unit was well staffed however, staff were often moved to cover other wards in the hospital where staff shortages were more acute. We were told that this appeared to be more of a problem at weekends.
- Staff on coronary care said that there were three vacancies but they managed to cover gaps in rotas by staff working additional hours. This was not seen as a major problem at the time of the inspection as the team worked well together to support each other and felt that this approach was necessary to ensure the unit was staffed by people with the appropriate skills and competence. The staff felt there were enough staff on duty to meet the patient's needs.
- We observed evening nurse handovers on Ward 22, 23, and 24, and found these to be systematic and thorough. They were led by the senior nurse using nursing folders and printed handover sheets. Each patient was discussed in detail including admission progress. Patients who were unwell and at risk of deterioration were highlighted which included signs to look out for and how to escalate. We also heard that one patient required three hourly turns. There were no interruptions during handover and staff demonstrated that they were familiar with the patients in their care. A handover we observed on Ward 16 started 15 minutes late and was not effective due to constant interruptions from the phone and call bells ringing.
- Bank and agency use was high. On the day of the unannounced inspection, we found one ward had five shifts covered by bank or agency.
- We were told that services relied on the good will of staff to cover additional shifts.
- The numbers of staff planned and actually on duty were displayed on each ward.

Medical staffing

- There are proportionately more junior medical staff in this trust compared to the England average, and fewer staff at Consultant level.
- We observed both morning and evening medical handovers, which took place in the Ops room. The handovers were organised and well structured. All wards were reviewed using the WebV system and all patients identified as 'at risk' were discussed as well as those who had a Do Not Attempt Resuscitation (DNAR) order in place. We thought the handovers were an example of good practice.
- Medical cover at night was one registrar, with two junior doctors; a foundation year 1(FY1) grade covered all of the medical wards and an SHO (Senior House Office) worked in the clinical decision unit. A A consultant on call supported them. The registrar was also responsible for covering the stroke unit and accident and emergency. During the unannounced inspection, there was evidence of delayed treatment and care due to the high workload of the junior doctor who was unable to see all patients on the wards in a timely manner.
- Two doctors we spoke to said they were concerned there was not enough medical cover at night. This view was also expressed as a concern at the junior doctor's focus group.
- The clinical decisions unit had four acute care physicians and a consultant attending the unit from 2pm Monday to Friday. During out of hours there was a consultant on call. A consultant told us that he thought they needed an additional consultant to do ward rounds in the mornings on the unit to improve respiratory mortality.
- There was a team of three consultant cardiologists, two specialist registrars (SPR) and 2-3 foundation year 2 (FY2) doctors covering coronary care unit, the angiography catheterisation laboratory, the cardiology ward and cardiology patients on the other medical wards. There was at least one FY2 doctor present on the unit at all times.
- From 5pm to 7am, the stroke unit had access to an on call consultant using a telemedicine service. The telemedicine service worked using a two way camera so the consultant could see and talk to the patient and vice versa. This allowed the consultant to advise the hospital doctors on a patient from the consultant's home.
- Junior doctors expressed concern around the performance of some locum staff. They felt able to share these concerns with managers and senior colleagues. We were told that on the planned investigation unit if locums perform poorly feedback was given to the agency.

Medical care (including older people's care)

- Based on information provided by the trust the turnover rate for medical staff in acute medicine at SGH was 23.23% and the sickness rate was 2.49% for the last financial year.

AHP staffing

- Staff on the planned investigation unit told us that the therapy team are very responsive.
- Allied health professionals in the stroke unit told us that staffing levels were good most of the time; they reported some difficulty with retention of band five therapists but stated that this was not a major issue.

Major incident awareness and training

- Staff we spoke to were aware of major incident and business continuity plans and where they could be found on the Intranet.

Are medical care services effective?

Good

We rated medical care as 'good' for effectiveness because:

- The matrons carried out quality audits every month on each ward. The results of the audits were shared with ward managers and any areas of concern were addressed with an action plan.
- The trust participated in national clinical audits scoring well in the Stroke Sentinel National Audit Programme, with an overall score of B.
- Data provided by the trust for the medicines directorate indicated that at Scunthorpe and Goole hospitals there was improvement in the number of medical and nursing staff who had managerial appraisal of their work performance from April 2014 to March 2015, compared with the previous year.
- Staff reported very good working relationships within the multidisciplinary teams.
- Staff met patients' needs for pain relief, nutrition and hydration.

Evidence-based care and treatment

- We checked policies and procedures and found that almost all of these were evidence based and up to date. The exceptions to this were the VTE policy and the Teaching Blood Glucose Monitoring policy, which were past their review dates.
- Local audits were undertaken by ward managers such as hand hygiene and documentation audits. Results were shared with staff at team meetings and results were displayed on wards in staff areas.
- Protocols and policies based on current evidence were available for staff on the ward and on the intranet.
- Ward 2 displayed on a notice board the theme of the month. They had scored 100% for carrying out foot checks on patients with diabetes.
- We found that there was a named respiratory consultant to manage patients with non-invasive ventilation (NIV). A maximum of four NIV patients were cared for on Ward 22. The recommended minimum staffing ratio of one qualified nurse to every two patients was met and there was additional support from the specialist outreach team.

Pain relief

- Most patients said they had pain relief if they needed it. Patients we spoke to on ward 23 said that their pain relief was well managed. One patient on ward 22 told us that the staff are caring but run ragged and there had been delays in accessing pain relief because the nurses were so busy. Another patient on the same ward said he always received pain relief when he needed it.
- Pain relief was documented in the patient's notes on ward 16 however, three patients' records had no pain score noted.
- A notice board in the staff room on ward 2 displayed a reminder to staff to ensure that patient's pain charts are completed on every medication round.

Nutrition and hydration

- We observed that a food and nutritional risk assessment tool was in place and that food and fluid charts were completed correctly.
- A notice board displayed information about malnutrition and how it is screened at ward level.
- Patients' nutritional needs were met. A patient on Ward 23 told us that she could only have a soft diet and this was catered for. Nursing staff told us that they could provide soup and yoghurts for patients requiring soft

diets and these were available outside of normal meal times. We spoke to a patient with learning disabilities on Ward 24 who required a gluten free diet. He told us that the food was great.
- Most patients told us that the food was good and that there was lots of choice however, one patient on ward 23 said the food was not good and that his wife sometimes brought food in for him to eat.

Patient outcomes

- Scunthorpe General Hospital scored well in the Stroke Sentinel National Audit Programme, with an overall score of B (on scale of A – E, with E being the worst) for April – June 2015 admissions.
- Data from the trust showed that preliminary results received for 2014/2015 data for the Myocardial Ischaemia National Audit Project indicate secondary preventions medications were now above or equal to the latest average results.
- Performance in the National Diabetes Inpatient Audit (2013/14) was mixed with the hospital performing better than the England average in 11 areas and worse in nine. We saw that action plans were in place to improve these services.
- There was a lower risk of readmission for both elective and non-elective patients at Scunthorpe General Hospital compared to the England average.
- The endoscopy unit were planning to move to a new purpose built unit. They hadThey had deferred their Joint Advisory Group on GI Endoscopy (JAG) accreditation application until after the move, as the new build wouldwould meet the criteria for the accreditation.
- At the time of the inspection, the trust was a mortality outlier for deaths from acute bronchitis and cardiac dysrhythmias.
- The trust had four quality matrons who completed monthly quality audits on each ward. The results were rated as red, amber and green and presented on a dashboard, which was displayed on the wards for staff and patients to see. For areas rated as red, the ward manager and the matron would createcreate an action plan in order to address areas of concern. We were told that if issues continued for three months then the ward manager and matron met with the quality manager to discuss the issue and form a comprehensive action plan for improvement. The matron we spoke to was able to give a good example of how this had led to improvement in the recording of fluid balances.

Competent staff

- Data provided by the trust for the medicines directorate indicated at Scunthorpe and Goole Hospital there was improvement in the number of medical and nursing staff who had an appraisal compared to the previous year. Seventy four percent of nursing staff had appraisals from April 2014 to March 2015 compared to 70% the previous year. Eighty two percent of medical and dental staff had appraisals from April 2014 to March 2015 compared to 40% the previous year. The trust target for appraisals was 90% and plans were in place to achieve this by April. Appraisal rates for staff on Ward 23 were 82% and CCU 85%.We were told that appraisals were sometimes cancelled due to staffing pressures.
- The matron informed us that appraisal rates were low on the planned investigation unit. We were told this was due to the unit manager being on sick leave and the matron was planning to complete these with staff soon.
- New staff on the coronary care unit staff were given a workbook. They were expected to undertake training and supervised practice until assessed as competent at each of the elements of care / intervention. Some of the tasks covered by the workbook were phlebotomy, blood transfusion, moving and handling and removal of femoral arterial sheaths. Nursing staff were supported by advanced nurse practitioners for aspects of more advanced practice. All nursing staff on the unit were trained in advanced life support.
- Nursing staff working as stroke responders had undertaken additional training in line with National Institute of Health Stroke Scale (NIHSS) guidance.
- The medical director is the responsible officer for medical staff and leads on appraisals and revalidation at the trust.
- On the planned investigation unit, locum staff received a local induction, which included an orientation to the unit, fire training and an introduction to medication charts.
- Locum doctors were encouraged to attend teaching sessions to keep their skills up to date.
- Allied health professionals told us they received annual appraisals and regular supervision.

Medical care (including older people's care)

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff indicated that multidisciplinary team working practices were in place.
- The stroke unit held regular multidisciplinary team meetings; these were held daily with the nursing and therapy staff and twice a week consultants were included. Community teams also attended these meetings when needed for discharge planning.
- Allied health professionals had good links and working relationships with colleagues working community teams and at Diana Princess of Wales hospital in Grimsby. They had a robust system for ensuring information; including care plans were shared to facilitate effective follow up and ongoing therapy after discharge or transfer. There were also good links with teams in other geographical areas for patients from out of the hospital area.
- An occupational therapist visited ward 18 as part of the Frail Elderly Assessment Team (FEAST). The occupational therapist worked closely with the physiotherapist to help integrate patients back to their homes.
- Ward 2 held regular multidisciplinary team meetings that included the patient and their relatives or an advocate, the consultant, junior doctors, social worker, therapists and nursing staff.
- We observed an example of excellent multidisciplinary teamwork in response to an incident, which occurred on the planed investigation unit during the inspection. The team worked together efficiently and effectively for the benefit of the patient.

Seven-day services

- Gastroenterology consultants were onsite at the weekend and there were plans in place to introduce a formal seven day on call bleed rota across the hospitals at Scunthorpe and Grimsby.
- Therapy staff working on the stroke unit viewed seven day working as a positive change and were working towards this. The current provision for occupational therapy was Monday to Friday. Physiotherapy had a reduced weekend service and covered on call for emergencies 24 hours seven days a week.
- Nursing staff on the stroke unit provided some therapy interventions on a weekend as instructed by the therapists.

Access to information

- Feedback from the health care assistant focus group and medical staff was that there were not enough computers to access emails and e-learning during work time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- On the notice board on ward 24, we saw a checklist for using an Independent Mental Capacity Advocate (IMCA).
- Staff we talked to on the endoscopy unit were aware that if a patient did not have capacity to give consent to a procedure, a best interest meeting should be held involving the patient, their relatives and medical professionals.
- Training records provided by the trust for medicine at Scunthorpe and Goole showed good levels of training for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) for nursing staff. Eighty eight per cent of nursing staff attended Mental Capacity Act training and 89% attended Deprivation of Liberty Safeguards training.
- Training was not so good for medical staff with only 38% attending both Mental Capacity Act and Deprivation of Liberty Safeguards training.

Are medical care services caring?

Good

We rated medical care as 'good' for caring because:

- Patients received compassionate care and were treated with dignity and respect. Their privacy was preserved.
- Patients and relatives we spoke with felt very happy about how they were looked after and said staff were kind, caring and patient.
- This trust had a higher response rate in the Friends and Family Test than the England average and a high proportion of patients who would recommend the service. The response rate for Scunthorpe General Hospital was 43.8% between July 2014 and June 2015.
- Patients felt involved in their care. They told us that doctors explained things well and they understood the information they were given about their care and treatment.

Compassionate care

Medical care (including older people's care)

- This trust had a higher response rate in the Friends and Family Test than the England average and a high proportion of patients who would recommend the service. The response rate for Scunthorpe General Hospital was 43.8% between July 2014 and June 2015. The clinical decisions unit and the planned investigation unit both scored 92% for positive comments in the friends and family test for the month of August.
- We looked at the results of the patient–led assessments of the care environment (PLACE). Scunthorpe General hospital achieved a privacy and dignity score of 89.98 % in 2015 against the national average of 86.03%.
- In the 2014 Cancer patient experience survey results for inpatient stay for this trust, 84% of patients said they were always treated with respect and dignity by staff. This was the same as the England average. In the survey one patient commented, "The chemotherapy nurses at Scunthorpe General Hospital were outstanding in caring and treating me".
- Most patient comments were positive about how the staff cared for them, however a minority identified some concerns.We spoke to five patients on ward 24 and all said they were happy with their care. They said the nurses on ward 24 could not be more obliging. A patient on ward 2 said he found the staff very friendly and caring. Patients we spoke to in the clinical decisions unit said the nurses were kind, caring and patient. We observed staff interacting with patients on ward 23 and found they were very caring and engaged well with patients. Privacy and dignity were respected.
- Comments that are moremore negative included a patient on ward 24 who told us that although the nurses were good and efficient there were not enough of them. They said that when patients press the buzzer it can takes a long time for them to respond and a patient was left for 20 minutes on the toilet this morning. Another patient said that sometimes the nurses talk very loudly at night and this disrupts sleep.
- On ward 16, we witnessed staff speaking about a patient's treatment within the hearing range of other patients.
- We saw one issue of privacy and dignity around a patientpatient who had exposed himself whilst catheterised. Two doctors, one nurse and one housekeeping assistant had all passed the patient and did not take anyany action. This was raised with the ward manager who took immediate action.
- The endoscopy unit does not currently have a designated room for sensitive conversations with patients and relatives. We were told that this would be available when the service relocates to the new unit, which is currently being constructed.

Understanding and involvement of patients and those close to them

- Patient told us that doctors explained things well and that they understood what they were saying, as they did not use jargon.
- We spoke to four patients on ward 23 said they felt involved in their care and felt very well cared for.
- A patient on ward 22 told us that when changes to his medicines were made this had been discussed with him. The reasons for the changes were explained in way he understood.

Emotional support

- We spoke to the parent of a patient with learning disabilities who was being cared for on ward 24 who said that she felt much supported by the staff who are very caring.
- The hospital provided chaplaincy support for patients.

Are medical care services responsive?

Requires improvement

We rated medical care as 'requires improvement' for responsive because:

- We found some issues whichwhich negatively affectedaffected patient access and flow. There were issues with flow through the hospital withward 2 (short stay wardward) and the clinical decisions unit often being unableunable to movemove patients to the most appropriate ward for their care.
- When we visited the angiography / cath lab we found that a delay in receiving a patient from ward 24 had resulted in another patient's procedure being cancelled. Staff told us that pre-assessments were not always carried out on every patient and inpatients were not always checked to see whether any preparation was required for the proposed intervention. This led to delays and cancellations.

- The endoscopy unit manager informed us that the demand on the unit fluctuated and occasionally patients had waited longer than the two-week wait standard. He said this was due to capacity of the treatment suites and because some of the consultants wanted to carry out the procedure themselves for their own patients and they were not always available.

However,

- Since July 2014, referral to treatment time in this trust has been above the 90% standard in all specialties measured.
- We found some good examples of patients' individual needs being met.

Access and flow

- Patients who were suspected as having suffered a stroke were admitted to the hyper- acute stroke unit from A&E. Patients moved from the A&E resuscitation room to x-ray for a CT scan then went directly to the unit if no thrombolysis was required. If thrombolysis was required, patients needed to return to the resuscitation room for thrombolysis before transfer to the unit.
- The hyper-acute stroke unit could accommodate up to six patients and was part of a larger stroke unit with a further 15 beds. Length of stay for the unit averaged around 24-48 hours but could be up to five days.
- Following the acute phase, patients were transferred into the lower dependency part of the stroke unit or back to their local hospital for stroke rehabilitation. It was reported that it was often difficult to re-patriate stroke patients back to their local hospitals due to bed capacity. This was particularly an issue when transferring patients to Diana Princess of Wales Hospital at Grimsby.
- When we visited the angiography / cath lab we found that a delay in receiving a patient from ward 24 had resulted in another patient's procedure being cancelled. The laboratory received patients from the planned interventions unit and from wards. We were told that patients attending the planned interventions unit tended to have had a pre-assessment before attending for angiography and that delays from this area were very rare. However, staff felt that pre-assessment was not carried out on every patient.
- It was also apparent that inpatients were not always checked whether any preparation was required for the proposed intervention. For example, patients could be cancelled due to medications not being stopped or INR tests not being carried out. Patients had been found at the last minute to have clotting times that were not in the safe range for the procedure to go ahead. The manager in this area told us that cancellations and delays were very frequent and happened every week.
- During our visit, the senior nurse in the cath lab was in the process of developing a pre-procedural checklist for ward staff to use. This would ensure patients were checked as being suitable for the planned procedure to go and reduce the likelihood of last minute cancellations and wasted appointment slots.
- One patient on ward 23 told us that there had been no delays to his procedure. He was also reassured that he had been given choices over the anaesthetic he was having.
- There was a discharge lounge to improve flow of patients through the hospital. However, there were no patients using the lounge at the time of our visit.
- We were told that the average length of stay on the clinical decision unit was 24 hours. Patients were often transferred to ward 2 (Short Stay Unit) or the planned investigation unit (PIU). Sometimes patients could be transferred straight to a medical ward however, on the day of inspection, one patient had been on the unit for a week as there were no beds available on the specialist respiratory ward.
- Ambulatory care was provided within an ambulatory care unit based within the clinical decision unit. The aim of the unit was to enable patients to be assessed, observed, diagnosed and treated without the need to be admitted into a hospital bed. We observed a copy of the standard operating procedure for the ambulatory care service.
- We were told that the maximum stay on ward 2 (Short Stay Ward) should be 72 hours however most patients stay longer. The longest stay for a patient was approximately 4 weeks. The reason given for this was that there were no other suitable beds and difficulty discharging patients with social issues. A nurse told us that the ward is slowly turning into a medical ward.
- The endoscopy unit manager informed us that the demand on the unit fluctuated and occasionally patients had waited longer than the two week wait standard. He said this was due to capacity of the treatment suites and because some of the consultants wanted to carry out the procedure themselves for their

own patients and they were not always available. The manager hoped this would improve in the new facility, as there would be an additional treatment suite. In addition, staff have signed up seven day working which means the facility could be used at weekends.
- Doctors we spoke to said there was pressure on endoscopy and they needed more consultants and endoscopy nurses.
- The average length of stay for medical patients at Scunthorpe General Hospital was generally lower that the England average with the exception of medical oncology and gastroenterology.
- Since July 2014, referral to treatment time in this trust has been above the 90% standard in all specialties measured.
- We were told that inappropriate medical outliers were sometimes sent to ward 18. Staff felt it was inappropriate to send patients with chest infections to the ward, which cared for patients who were immunosuppressed. One nurse had asked if a patient could be swapped with another patient with a more stable condition but had been told no by the bed manager.
- The electronic patient system allowed filtering of all patients, in the medical service, by consultant to enable a list to be printed of all outlying patients needing a review. This reduced the risk of outlying patients being "lost".
- Outliers on ward 18 were seen by their own doctors Monday to Friday and by on-call doctors at the weekend. The medical team were made aware of outliers at handover.
- Information regarding bed moves, between April 2014 and March 2015, indicated that across the medical service for the trust 48% of patients were moved once during their stay, 13% were moved twice, 3% three times and 2% of patients were moved four or more times. This equated to 336 patients across both hospital sites being moved four or more times during their hospital stay. Evidence from the Royal College of Physicians has shown that every ward move increases patient length of stay. There was a 1% improvement of numbers of patients being moved two and three times during their stay from the previous year.
- The bed manager told us that the aim of his role is to ensure right person is in right bed at right time and to improve flow out of hospital as well as in. As pressures increase, escalation processes/ protocols were put into play and matrons joined the ops meetings to support this. Community matrons may input at times of escalation to help discharge patients where possible to community services. He told us that the current position is calibrated at least two hourly throughout the day and reviewed at 4pm to assess the situation for the coming evening/ night shift.

Meeting people's individual needs

- We were told that learning disability training was led by a quality matron and training was in progress across the trust, however, uptake was low. Ward 23 and 24 both had a learning disability link nurse who attended updates provided by the quality matron and shared the update with staff on their ward.
- A patient with learning disabilities was being cared for on ward 24. The patient's parents told us that were very happy that they were able to stay with their son 24 hours a day and that staff had been supportive.
- Staff on ward 24 told us that there is a telephone translation service called 'The Big Word' which is available for patients who did not speak English. Face to face interpreters (including British sign language) were also available and could be booked via the PALS office.
- A matron is responsible for leading on dementia and provides advice and training for staff.
- We were told that ward 23 was working towards being more dementia friendly with staff receiving training and new equipment being ordered.
- Staff on ward 2 had either completed dementia training or were booked onto do training soon. Two health care assistants we spoke to on the clinical decisions unit had not completed any dementia training and said they would like to but it was always booked up.
- Staff on the coronary care unit told us they used "My Life" booklets and "Memory Boxes" when they were caring for patients with dementia. Staff described working with carers and communicating with care homes to enable an understanding of the care needs of individual patients with dementia.
- A relative's room was available on ward 2. A homely environment had been created with a sofa, TV and a mock fireplace. There was also a memory box for patients with dementia.
- We were told that there had been no mixed sex breaches reported for the stroke unit. We looked at

mixed-sex accommodation data available on the NHS England website, which confirmed there had been no breeches reported by the trust from October 2014 to October 2015.
- There was good information available for patients and relatives at the entrance to the coronary care unit. Signage to the unit was good.

Learning from complaints and concerns

- A matron told us that they try to deal with complaints on the ward level whenever possible.
- Complaints and compliments were shared with staff on ward 2 in a regular newsletter. We were told that they were also discussed at staff meetings, which occurred three times a year.
- Ward meetings were held on the stroke unit and incidents, complaints, updates to practice and safety alerts were highlighted. As it was not possible for all staff to attend, the ward had a communications file for important information / updates and staff were expected to read and sign to say they had read the information placed there.
- We looked at a response the trust had made to a formal compliant and found it to be thorough. Learning points from the complaint were clearly documented including how this learning would be shared with other staff.

Are medical care services well-led?

Good

We rated medical care as 'good' for well-led because:

- Overall, the wards we visited appeared well organised and managed. Action had been taken on wards that had been previously failing, which had led to improvements.
- The lead consultant for the stroke unit had a clear vision for ongoing improvements and development.

We saw some good examples of teams working well together. Most staff spoke well of their immediate line managers and found them to be supportive.

- Ward managers said they felt well supported by their matrons. Matrons visited the ward several times a day and met with them monthly to discuss the quality dashboards.
- Ward staff told us that the chief nurse was often seen on the wards and was approachable.

Vision and strategy for this service

- There was evidence that stroke services at Scunthorpe had benefitted from development and investment over recent years and the lead consultant had a clear vision for ongoing improvements and development. A business plan had been developed and submitted to the executive team for consideration and investment. All members of the multidisciplinary team were aware of the plans and had been consulted on their development.
- We saw that a notice board on clinical decisions unit displayed the vision of the unit.
- There was clear vision, among senior managers, for improvements to some clinical services such as stroke services and gastroenterology although it was recognised that staffing issues and vacant clinical lead posts in some specialities was inhibiting development. This was particularly the case in cardiology and acute medicine.

Governance, risk management and quality measurement

- A comprehensive risk register was held centrally for the directorate of medicine and showed that existing / ongoing risks had been reviewed between January and August 2015.
- Staffing issues including recruitment difficulties for nursing and medical vacancies and reliance on locums was logged on the directorate risk register. There were regular updates on what actions were being taken to reduce this risk.
- Matrons and senior nurses were clear how to escalate risks through the relevant governance processes. Matrons told us that they escalate risks through monthly meetings with the governance facilitator and business unit manager. Ward managers escalated their risks through monthly performance meetings.
- Managers were clear about the risks their departments or services faced and minutes of governance meetings clearly demonstrated discussion, escalation and actions taken.

- Results of ward audits against measures of quality were entered onto a dashboard, which was shared with staff through team meetings, and results were displayed in staff areas. Ward mangers could demonstrate improvements to quality measures over time.
- There were internal quality assurance systems and processes in place to investigate and review any clinical concerns or issues and to make recommendations and improvements. For example, work streams had been introduced to undertake mortality reviews around clinical specialities.

Leadership of service

- There was a lead clinician for the stroke unit at Scunthorpe hospital. Two doctors we spoke to on the stroke unit told us that the unit was well organised. They had weekly meetings and felt that the lead consultant was a good teacher. The unit manager on the stroke unit told us that they had a good working relationship with the consultant and medical staff. Therapists confirmed that leadership was good and change over recent years had been well managed by leaders of the multidisciplinary team.
- At ward level there was clear leadership of the services however ward managers were not always supernumerary to staffing numbers and this sometimes affectedaffected their ability to lead their ward.
- The ward managers were supported by an operational matron and a number of quality matrons. Matrons gave good support to the ward managers regarding day to day operations as well as monitoring performance against quality indicators. Ward managers told us they felt well supported by the matrons who visited the ward several times a day.
- There were clear lines of accountability from the service leaders to the frontline staff.
- We saw that on wards where concerns had been identified, work had been undertaken to improve the workload organisation, team working, and staff morale. Action plans for improvement had been put in place with timescales.
- Ward mangers and junior sisters had access to line manager training.
- Most of the staff we spoke to spoke well of their immediate line managers and found them to be supportive.
- A matron we spoke to told us he was aware that staff were working additional hours on the bank and that he tried to monitor this was not having an adverse effect on their health by discussing this with staff.
- Staff told us that they often saw the chief nurse who was approachable and matrons were seen on the wards every day.
- Consultants told us that they felt increased liaison and commitment from management was needed.
- Sickness absence levels across the trust were similar to the England average (January 2011 – January 2015).

Culture within the service

- Most staff we spoke with were positive about the culture of the service.
- An incident occurred during the inspection. We observed this and saw good clinical leadership in managing the situation. We also saw that junior staff were empowered to challenge senior staff in order to improve the outcome for the patient.
- Nursing staff and doctors on the clinical decisions unit told us that they work well together as a team and felt well supported by the unit manager. A student nurse commented that it was a good environment in which to learn and staff were very helpful.
- Staff on ward 2 told us they worked well together as a team. We saw examples of good practice, a communication book in the staff room for staff to pass messages to each other and a notice board displaying information on a theme of the month: foot checks for patients with diabetes.
- The ward manager on ward 24 told us there were good relationships between the consultants and junior doctors.
- A matron we spoke to said that the organisation had an open, supportive and listening culture.
- Staff on ward 18 said that they often feel that no one from the senior team recognises and thanks them for the work they do.

Public engagement

- We saw notice boards on the wards displaying 'you said we did' information with details of how the ward had responded to feedback from patients. One example was how a ward had introduced a drinks round in the late evening in response to what patients had said.

Staff engagement

Medical care (including older people's care)

- Messages were shared across the organisation using weekly newsletters and the chief executive had introduced a blog for two-way communication with staff.
- A matron we spoke to said she felt valued. The trust had a Star Awards scheme and staff were able to make nominations and have a say in who wins the awards.
- Staff on the stroke unit told us communications between the team were good. Team meetings were held and a communications book and suggestion box was in place.
- Staff on the coronary care unit told us there had been a recent meeting with staff to discuss the future of the planned investigation unit and Cath lab.
- Staff attending the health care assistant focus group told us they were listened to by their ward managers but that sometimes they felt their managers were restricted in what they could do by more senior managers.
- One nurse said she felt that the trust is run on the goodwill of the staff not wanting to let colleagues down.

Innovation, improvement and sustainability

- A rotation between nursing staff on the clinical decisions unit, ward 2 and ward 17 was being set up to give staff from other wards an insight into what it was like to work on the unit. The aim was to break down negative perceptions and to encourage staff to apply for vacant posts on the unit.
- The stroke unit used a telemedicine service out of hours to contact the consultant for clinical advice on a patient.

Surgery

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

Information about the service

Scunthorpe General Hospital (SGH) provides day surgery and inpatient surgical treatment for NHS patients across a range of specialities, including colorectal surgery, ear, nose and throat, ophthalmology, orthopaedics, urology, and general surgery. Surgical beds are located on inpatient wards and a day case ward. Seven operating theatres are available.

Between January 2014 and December 2014 there were 41,020 surgical episodes of care carried out in the trust, with 16,800 carried out on the Scunthorpe site. Day cases accounted for 64% of all episodes, with emergency admissions 26% and elective (planned) admissions 10%.

At our last inspection in July 2014, we found that surgery required improvement overall. We rated surgery as 'requires improvement' for being safe and well led and as 'good' for being effective, caring and responsive. During this inspection, we reviewed progress made against the action plan for improvement produced by the trust following the 2014 inspection.

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

We spoke with 25 patients, nine relatives and 57 members of staff, including ward managers, nursing staff, medical staff (both senior and junior grades) and allied health professionals such as pharmacy and physiotherapy staff.

We reviewed 17 care records including medication charts and we received comments from patients to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

Surgery

Summary of findings

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

- Surgical services did not always protect patients from avoidable harm and there was a limited level of assurance with safety measures.
- In 2014, we said the trust must take action to ensure that there was sufficient qualified, skilled and experienced staff, particularly in surgical areas. During this inspection, we found substantial and frequent shortages of nursing staff and an increased number of agency staff being used. When staff shortages occurred, the skill mix of staff was not always a priority.The trust had run a significant recruitment campaign but the skill mix and retention of new staff remained an issue. Newly qualified nurse, awaiting their national registration, were often included within the qualified staffing levels. Many staff commented on an increased amount of pressure for experienced/ substantive staff due to staff shortages. The overall number of vacancies had increased since our inspection in 2014 despite the trust's efforts at recruitment.
- We found that although staff reported incidents, the lessons learned from investigating them were not always fed back or shared effectively with all surgery staff, to help prevent the incidents from happening again.
- We had concerns regarding the pre-assessment of patients; the assessment of early warning scores for deteriorating patients; and the provision of emergency equipment. Assurance for compliance with the team brief element of the five steps for safer surgery was limited.
- Patients were at risk of not receiving effective care or treatment, as care provided did not always reflect current evidence-based guidance, standards and best practice. Implementation of best practice guidance was variable, with 65% of policies compliant with current National Institute for Health and Care Excellence guidance as of September 2015..
- National hip fracture audit data for 2014 showed SGH performed better than the England average on most of the indicators. However, there had been deterioration in performance at SGH in six of the areas reported on in 2014 compared to 2013.
- Appraisal rates had improved since 2014, however still did not meet internal compliance targets and levels of compliance across surgical wards and departments were variable.
- Services did not always meet patients' needs. They were not always able to access services for assessment, diagnosis or treatment when they needed them. There were long waiting times, especially in urology, pain procedures, ophthalmology and trauma and orthopaedics. Patients we spoke to and evidence we reviewed showed that patients were experiencing delays and cancellations of operations and procedures. Actions taken to deal with this were not always timely or effective. A number of medical patients were using surgical beds, which limited the availability of beds for surgical patients.
- Patients' needs were not always taken into account. Patients were not always able to access services for assessment, diagnosis or treatment when they needed to. There were long waiting times for some specialities.There was no surgical vision statement or overarching surgical strategy. We were told that some of the future service provision would be determined through the ongoing local health community "Healthy Lives, Healthy Futures" work stream. Risk issues were not always dealt with appropriately or in a timely way.
- It was noted in the 2014 inspection, that the senior management team was new at that time and had not had time to implement changes. During 2015 further change to the senior management team had taken place. Managers had not yet identified, prioritised and taken action on all of the issues of concern within surgery. Potential improvements from the introduction of the quality and safety days had not yet become an established route for learning.
- During the inspection, we saw improved leadership on surgical wards from ward managers.

Surgery

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

Are surgery services safe?

Inadequate

We rated surgery as 'inadequate' for safe because:

- In 2014, the trust was asked to take action to ensure that there were sufficient qualified, skilled and experienced staff, particularly in surgical areas. During this inspection, we had significant concerns over substantial and frequent shortages of nursing staff and an increased number of agency staff were being used. Skill mix of staff was not always a priority when staff shortages occurred. A significant recruitment campaign had taken place, however the skill mix and retention of the new staff employed remained an issue. Newly qualified staff, awaiting their registration, were often included within the numbers for registered nurses, which places an increased amount of pressure on experienced staff. We noted that overall vacancies had increased, despite active recruitment.
- Surgical services did not always protect patients from avoidable harm and there was a limited level of assurance about safety. Safety concerns were not always highlighted, in a comprehensive or timely way. Learning from previous serious incidents and never events was not always evident and actions were not always taken to improve safety. Staff reported incidents, however they told us that they did not always receive feedback following investigation.
- We had concerns regarding the pre-assessment of patients. The senior management team were aware of the issue and an "Acceptance that improvements could be made", was noted in the theatre action plan.
- During the inspection we raised concerns that checklists and protocols for resuscitation equipment were not up to date in some areas we visited. Immediate action was taken by the ward manager to address this. Assurance for compliance with the team brief element of the five steps for safer surgery was limited.
- Although compliance with mandatory training (at 82% in November 2015) and appraisal levels had increased, it was still below the trust compliance rate of 95%. We reviewed data from a spot-check internal audit report on the assessment of early warning scores (NEWS) for deteriorating patients from April 2015. This showed low compliance with NEWS score assessment standards of

between 50% and 78%. Nursing audit data we reviewed for July 2015, showed improvement to 93.2% compliance with patient indicator standards including recording NEWS scores.

Incidents

- A centralised national computer system was used to report and investigate incidents. Surgical services reported 1,907 incidents (graded as harm which was no, low, moderate, severe, resulting in death or abuse) to the National Reporting Learning System (NRLS) between July 2014 and August 2015. Reported incidents showed three resulted in death, one graded as severe harm, 34 graded as moderate harm, 604 graded as low risk harm and 1,265 graded as no harm/near miss.
- Senior nursing and medical staff reviewed the incidents reported and analysed the data to identify any trends, monitor actions and learning. The top three categories of incidents reported were; patient accident (451 of 1,907 total incidents), implementation of care and ongoing monitoring (429 of 1,907) and infection control incidents (264 of 1,907). Staff we spoke to, said that the top incidents were falls and pressure ulcers.
- Nursing and medical staff we spoke to, were all aware of the centralised system for reporting and staff could describe their roles in relation to the need to report, provide evidence, take action, triage or investigate as required. Staff did however report to us that they did not complete incident forms following every incident. Some staff we spoke with also saidthat they had not received individual feedback on incidents they had reported..although the IT system had a mechanism to provide this.
- Some staff told us that learning from incidents was shared internally through staff meetings, communication books and white boards within staff-only areas. Daily team briefings were used in one area to share information between staff members. Learning from incidents between the surgery group sites was limited. A surgical quality and safety meeting had been developed. All medical and senior nursing staff were invited to attend, to discuss themes and issues identified through governance. This meeting had been held on three occasions before this inspection. However; it was not clear how messages from this newly established meeting had been cascaded to ward level staff to date.
- Serious incidents (SIs) are incidents that require further investigation and reporting. From data provided by the trust there were 19 SIs reported trust wide within the surgery group during the reporting period August 2014 and July 2015. Themes included pressure ulcers, delays in diagnosis, surgical error and unexpected death. We reviewed four reports and noted a good quality of investigation and identification of lessons learned; however dissemination of the report, implementation of lessons learned and evidence of change in practice could have been emphasised further.
- Never events (NE) are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. No never events had been declared on the SGH site in the reporting period. However, some staff we spoke with, were aware of the NEs which had occurred at Diana Princess of Wales (DPoW) hospital. Within theatres, the findings had been shared verbally and a read and sign document system had also been developed. One NE related to the wrong ophthalmic lens being used. There was the potential for a similar incident to occur as there was no consistent approach or standard operating procedure in place across all theatres to check ophthalmic lenses prior to implementation.

Duty of Candour

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

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harm and ‘harm free care’. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), and catheter and urinary tract infections (CUTIs).
- During the 2014 inspection, safety thermometer data was clearly displayed on information boards on every surgical ward area. During this inspection, safety thermometer data was not always on display in the

clinical area. A specific section of the quality board was available for display, however this section was found to be not completed in every area visited during the inspection or unannounced inspection.
- In the reporting period July 2014 to July 2015, 77 incidents of harm were reported in the surgical area with 54 pressure ulcers, 16 falls and 7 CUTIs.

Cleanliness, infection control and hygiene

- Infection prevention and control (IPC) training was delivered both face to face and via e-learning. The IPC team delivered face-to-face training. IPC training compliance rates for the Surgery group were 79% with a trust target of 95%.
- Ward managers undertook measurements of compliance with key IPC trust policies on a monthly basis, including; cannulation, environmental cleaning and catheter management. The Matron and IPC team completed verification of the audit.
- During the inspection, we observed compliance with some IPC policies for example the 'bare below elbows' theatre uniform policy. However, compliance with the patient isolation policy was variable. Rooms used for isolation of patients had the door left open and standard precautions and hand hygiene policies were not always followed due to sinks being cluttered and difficult to access. Sharps bins were seen overflowing and in one area (ward 11), a sharps bin had been in use for over a year.
- Hand hygiene audit data showed compliance of 100%. During the inspection, we noted good availability of alcohol hand rub. Soap dispensers we reviewed were all in working order. We noticed good compliance with hand hygiene principles in theatres but within one ward area (ward 11), we observed staff not always using hand hygiene principles between episodes of patient care.
- Within the trust, reported cases of hospital acquired infections were above the thresholds agreed, with one reported case of Methicillin resistant staphylococcus aureus (MRSA) and two reported cases of hospital acquired Clostridium difficile (C.diff) in the reporting period April 2014 to April 2015.
- Pre-operative surgical patients were screened for MRSA. Compliance with the MRSA and C.diff policy was audited; compliance was approximately 90-100% between January 2015 and July 2015 against a trust target of 100%.
- Surgical site infection data showed a low level of surgical site infections, with one knee replacement infection and no infections for hip replacement or repairs of neck of femur fracture noted during the reporting period January to March 2015.
- Environmental cleaning schedules were available and displayed. We reviewed patient led assessment of the care environment (PLACE) results and noted a score of 95.57%, slightly below the national average of 97.57%. During the announced inspection, the inpatient environment was visually clean. During the unannounced inspections cleanliness showed mixed results with high levels of dust being found behind lockers and on bed frames.
- Equipment cleaning labels provide assurance to patients that re-usable patient equipment was clean and ready for use. During the inspection cleanliness labels were available and used. However, their use was not always consistent or documented with the date of cleaning or the name of the person who had carried out cleaning.
- All commodes we observed were clean and in good condition. Cleanliness labelling was used; however, not every label was signed and dated.
- Water checklists used for recording flushing of water systems we reviewed were complete. Water coolers were in place however, no evidence of flushing or testing of these was available on the ward environment.

Environment and equipment

- Storage for equipment was poor in some areas and the patient environment was cluttered with shared patient equipment such as fans, drip stands and chairs, which made cleaning difficult. We found theatre trolleys stored in the main corridor, these were not covered with protective sheeting or marked as clean, and were not protecting from tampering.
- We found two of the resuscitation equipment trolleys were unsealed.. Records of daily checks and assurance of testing was not always evident as per guidelines, and trolleys were found to be dusty. Staff we spoke with, were not always aware of how to open the resuscitation trolleys and resuscitation policies on or adjacent to the trolley were out of date. Defibrillation equipment was shared between some wards; defibrillation equipment was different in some areas of the trust, which made training and declaring competency difficult, especially for staff that moved around the hospital. Post-

inspection, the trust provided information that showed for consecutive years, at each site, two types of defibrillators had been used due to a change of the manufacturer,

- When using heat generating equipment in operating theatres, surgical smoke is produced. Surgical smoke scavenger systems are in place to protect patients and staff from risks of ill health from exposure to surgical smoke. We observed that surgical smoke scavenger systems in theatres were available but not in use. It is recognised that no specific legal requirement for surgical departments to install smoke extraction systems is available, however employers must comply with COSHH regulations to control the exposure of their staff from surgical smoke. The Health and Safety Executive note that there is sufficient evidence to consider the use of surgical smoke extraction devices in reducing the levels of smoke exposure for health care workers. The British Occupational Hygiene Society standards recommend that evacuation and filtering of surgical smoke systems is used; however, it is noted that occasions are possible where the machine could prevent surgical access and it would not be used.
- Emergency trolleys we observed in theatres were clean and well stocked. Airway equipment in theatres was stored in inappropriate containers that could become contaminated.
- Within theatres, we observed surgical tape used to attach surgical drapes to drip stands, rather than clips. Sticky tape and surgical tape was also used to attach posters to walls in the theatre area, which can leave a residue, which is difficult to clean and prevent cross infection. Residues of surgical tape were observed on the theatre tables and associated attached equipment within orthopaedic theatres.
- Oxygen cylinders were not secured to the walls in theatres as per good practice guidance.
- Some staff highlighted to us that decisions around purchase of equipment were led by procurement and not by clinician or user. An example of this was where a piece of patient equipment had failed and had led to patient harm, but due to financial pressures, staff were discouraged from removing equipment from use.
- Laser equipment had been recently purchased in theatre. Staff expressed concern about the supplementary equipment provision, the levels of training provided and competence for using this piece of equipment.Procedures were not in place for when the laser was in use and posters to discourage access were not visiable.

Medicines

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

Records

- We reviewed 20 sets of medical and nursing care-plans whilst on site, the majority were fully completed, legible, and completed in a timely manner.
- All surgical wards completed risk assessments; these included risk assessments for blood clots, falls, pressure ulcers and malnutrition. All records we reviewed were completed.

- Review dates on forms were not always clear, we found medical and surgical Venous Thromboembolism (VTE) forms in use, which had different review dates and it was not clear from the forms when they were due to be reviewed again.
- In 2014, the trust was asked to ensure the reasons for 'do not attempt cardio respiratory resuscitation' (DNACPR) decisions were recorded and were in line with good practice guidelines. DNACPR records we reviewed during the inspection showed mixed compliance in terms of discussion with family members to put the DNACPR in place. We observed that no review of the DNACPR decision had taken place post-operatively, when the emergency situation may have changed. This was also the case when patients were diagnosed medically fit, or when they were transferred between hospitals. It is recognised as good practice to record further discussions throughout the patient's hospital stay. There was no consistent approach to completing DNACPR records.
- A computer system had been developed since the last inspection. Web V contained patient assessments and care records.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by three-yearly safeguarding refresher training. We were unable to review individual surgical compliance data as the trust told us they do not collect this data in this format.
- Nursing and medical staff we spoke to, were aware of their responsibilities and pathways to protect vulnerable adults and children, including escalation to the relevant safeguarding team as appropriate.

Mandatory training

- In 2014, the trust was asked to ensure that all staff attend and complete mandatory training, particularly for safeguarding children and resuscitation. We reviewed mandatory training records for the surgery group, which showed overall training compliance of 82% in November 2015 against a year-end trust target of 95%. Although not achieving the trust's own compliance rate (of 95%), improvements were noted from 2014; training levels for surgical wards had improved from 75% in 2014 to 82% in November 2015. Theatre compliance had improved from 66% in 2014 to 82% in November 2015. Medical staff compliance with mandatory training had improved from 50% in 2014 to 71% in November 2015.
- Although mandatory training compliance rates had increased, staff within some areas said they did not get time to undertake e-learning or face-to-face training due to staffing levels and activity. Some staff told us they were completing e-learning within their break times.
- In some specific areas of training, compliance remained low e.g. fire training had 49% compliance for one area. We were unable to review individual compliance data as the trust told us they do not collect this data in this format.

Assessing and responding to patient risk

- In 2014 the trust was asked to ensure availability of emergency theatre lists at this hospital. We observed that access to emergency theatre lists had improved and was now offered seven days a week for part sessions. At the weekend, trauma and emergency lists were joint. Staff working in orthopaedics told us that on some occasions this made it difficult for orthopaedic cases to access theatre in a timely manner.
- In 2014, the trust was asked to ensure the World Health Organisation Safety Checklist (WHO) was fully embedded and audited appropriately in theatres. Internal audits in 2014 showed compliance with WHO audits below 62%. Audits of retrospective documentation we reviewed during this inspection showed 88% compliance in February 2015; however, in August 2015 the Trust's own level of assurance had dropped to "limited". During the inspection, we observed two WHO checklists taking place and noted variable compliance; one was undertaken appropriately and one where new staff entering the theatre were not being introduced during the list. The name of the person completing the record has been removed from the WHO audit document. The trust told us this was to encourage full team responsibility for completion..
- We reviewed theatre booking forms and noted that allergies, complications and signature of doctors undertaking bookings, were not documented on the booking form. No highlighted section for high risk patients was available on the form, which made infection risks or latex allergies less obvious. We discussed this with the theatre management team and

staff told us this information would be communicated verbally and no formal process existed.the trust informed us post inspection, that the booking forms were being reviewed.

- The computerised patient system allowed for the assessment and recording of National Early Warning Scores (NEWS) to be recorded. This score was highly visible on the ward, used during handover meetings in central areas and whilst medical staff were on-call in the hospital. Audit data we reviewed from a spot-check internal audit report on the assessment of early warning scores for deteriorating patients April 2015 showed limited assurance and poor compliance with observations recording, increasing observation frequency, and informing senior staff when patients were deteriorating. Compliance results were between 50% to 78%. Nursing audit data we reviewed for July 2015 showed improvement to 99.1% compliance with the patient indicator standards including recording NEWS scores.
- One of the never events at DPoW hospital was linked with changes to theatre lists. We reviewed how theatre lists were changed and communicated. Most staff we spoke to within the theatre environment told us that changes to theatre lists were made regularly and made in real time onto the computer system which was available to staff. However, staff relied on printed versions of the lists and staff told us that they always checked centrally prior to collecting patients for operations. During the inspection we reviewed current arrangements for emergency theatre lists at this hospital and noted no formal procedure was in place. It was noted on the theatre action plan that improvements to emergency theatre booking procedures had been reviewed and a form had been produced, however it required agreement and implementation. The deadline for completion of this process was noted as August 2015 in the action plan and therefore not yet achieved at the time of the inspection.
- Concerns were raised during the inspection and corroborated with discussion with staff over the pre-assessment process and the staffing levels. Few pre-assessment pathways were available. This resulted in patients being listed for day case operations when they were unsuitable and required overnight stay. A number of surgical cases were cancelled, due to inappropriate pre-assessment. The senior management team were aware of the issue and; “acceptance that improvements could be made” was noted in the theatre action plan. Pre assessment clinics were not all located together on site; as result of this the senior management team said they were currently unaware of how many pre-assessment appointments were available, however they were undertaking a capacity and demand assessment.
- Specialised prevention equipment (such as specialist boots) can be placed on patients to prevent blood clots forming during operations. There were no specific protocols in place for staff to decide whether to use the preventative equipment on high-risk cases. In discussion with senior staff, we were told this was an individual surgeon’s decision.

Nursing staffing

- At the 2014 CQC inspection there were 27 whole time equivalent (WTE) trust wide surgical vacancies reported. During this inspection the senior management team, told us that the current vacancy rate was 50 WTE registered nurse vacancies within the surgical and critical care division. The trust was actively recruiting to nursing vacancies across the trust including overseas recruitment. All staff we spoke to were concerned about the number of nursing vacancies, and all wards we visited had vacancies.
- The Safer Nursing Care Tool was in use in the surgical areas; the acuity of patients was assessed and recorded into the Web V system three times a day. The staff we spoke to were aware of their responsibility to update the system. The matrons reviewed patient acuity and flexed staff up or down where feasible. The current established working staffing ratio for the trust was 1:8 nursing staff to patients with an aspirational ratio of 1:7. Ward managers were often shift co-ordinators and counted in the numbers of registered nurses.
- During the inspection we saw ratios of 1:11. We witnessed the impact of staffing levels, for example, during an evening visit patients were waiting to be moved and transported to the toilet. Staff from another ward were requested to help.
- We reviewed staffing rotas on every area visited; we reviewed 672 shifts (52 days) in detail and found that staffing levels for registered nurses were below the established levels on 36% of occasions. On 218 occasions, the registered nurse establishment included

agency staff. On average 19 different agency staff were used per month. When wards did meet established levels, this was often with agency staff and newly qualified nurses awaiting their professional registration.

- On ward 28, from the 84 shifts we reviewed, more than two agency staff were on duty at any one time for 11 occasions.
- There was a high observation bay (HOB) with four beds on ward 28 (24 beds) for surgical patients. The patients in the HOB required extra nursing and medical support than ward patients. We reviewed staffing levels in this area and noted that one RN and one HCA were rostered to care for the HOB patients. Overnight on ward 28 there were two RNs and an HCA on duty. Staff working in this area told us that the breaks for the qualified member of staff were covered by the HCA. This left ill patients without a qualified member of staff within the bay area. If RN support was received from ward 28 this then left one RN on duty on the ward with 24 patients.
- Staffing overnight on the trauma and orthopaedic wards (wards 10 and 11) was concerning. Staff told us and we saw evidence of, three registered nurses being allocated for duty across both wards, one nurse was allocated to each ward with the other nurse floating between the two wards. When full these wards had 32 patients spread over two floors. On reviewing staffing rosters for 28 night shifts, three registered nurses had been on duty on 19 occasions. Agency staff made up part of the three RN shifts on 14 occasions.
- We spoke to 25 patients over four wards. On wards 10, 11 and 28 nine patients spoke about negative aspects of care, themes were poor communication and staffing levels. On ward 11 all five patients we spoke to were unhappy with the level of care they were provided. They gave examples of not being enough staff to take them to the toilet, and that they don't have enough time to see you". Some we spoke with told us that "staff were run off their feet" and provided examples of when they felt staffing levels were low and buzzers were not answered quickly.
- A large amount of recruitment had taken place throughout 2014. During the inspection, concerns were raised that newly qualified recruited nurses awaiting their professional registration were being recorded as band 4 staff but counted in the numbers for registered nurses (RNs) on duty. Counting newly qualified nurses awaiting professional registration as RNs on duty was concerning, as these staff needed extra supervision and could not carry out all tasks such as administering medicines that a registered nurse could. This placed extra responsibilities on the substantive members of staff. Senior staff spoke to us about their concerns about this practice, we reviewed duty rosters and noted every surgical ward visited were counting nurses awaiting their professional registration in the RN numbers. Out of 61 duty shifts allocated to band 4 nurses, they were counted in the registered nurse numbers on 52 occasions.
- During the unannounced inspection we were made aware that a memo had been circulated to matrons since the inspection, advising managers not to roster newly qualified nurses awaiting their registration as registered nurses if less than two substantive qualified RNs were on duty. Staff we spoke to told us that whilst working as newly qualified nurses awaiting their registration, they were not allowed to administer medication. Senior management confirmed this.
- These nurses also required a second signature on documentation and could not undertake complex wound dressings. This level of extra supervision required, when already short staffed was increasing pressure on other registered nurses to support the new member of staff.
- A large amount of international recruitment had taken place and staff spoke to us about language difficulties of some of the staff recruited. We had received similar concerns from some stakeholders and patients pre inspection. When raised this with the trust and were told that all nurse candidates must have intermediate level English as a minimum requirement before being selected for interview. Following induction all candidates must reach level 2 standard.
- In the previous year, a new shift system had been implemented; this shift system consisted of "blended shifts" which were a mixture of early, late and long day shifts. Staff we spoke to told us that this shift system had led to an increased number of staff leaving the trust. Some areas had subsequently returned to the previous shift pattern of just long days. The trust acknowledged that staff had left due to the shift changes and also said they had left for community roles.
- Shift co-ordinators on each ward also had a cohort of patients to care for. This was raised at the time of inspection and the trust informed us they were undertaking a review of nurse staffing levels and developing the shift co-ordinator role.

Surgery

- Staff told us that due to staff shortages, they did not always get time to complete records accurately and record information on the IT system.
- The senior management team were aware of the staffing issues and were collectively working on new role development such as Band 4 theatre assistant roles, and advanced care practitioner roles. Some of these new roles, such as ACPs would take over 12 months to implement in order to ensure appropriate training and qualifications had been obtained.
- Staff had handovers twice a day, with "safety huddles" throughout the day as required. We observed a safety huddle and found this to be thorough, informative and staff appeared knowledgeable about their patients.

Medical staffing

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

Major incident awareness and training

- Staff we spoke to were not aware of any major incident scenario training sessions being carried out in the previous year.
- Staff we spoke to were not always aware of evacuation or safety procedures from orthopaedic theatres in case of fire or major incident.

Are surgery services effective?

Requires improvement

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

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

Evidence-based care and treatment

- During the last inspection there were concerns raised about the availability of access to emergency theatre lists as recommended in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report. Access was available daily through a mixture of all day and half day theatre sessions. Data we reviewed showed 85.3% use of emergency theatres. Some staff told us that access to emergency theatres for trauma patients was difficult as no dedicated emergency list was available on a Saturday.
- Departmental policies were based on nationally recognised best practice guidance, for example National Institute for Health and Care Excellence (NICE) guidance. However, data supplied to us by the trust, showed that

in September 2015, 65% of policies were fully compliant with NICE guidance, 26% were partially compliant and 7% were yet to be assessed with a small number of policies being non-compliant (May 2015).
- Local and national resuscitation guidelines and policies located on the resuscitation trolley were found to be out of date (dated 2005). New guidelines were available on the local intranet, which were published in 2015.
- Enhanced recovery care pathways we reviewed for orthopaedics were undated, or did not have a review date included.

Pain relief

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

Nutrition and hydration

- In 2014, the trust was asked to review access to the provision of soft diets outside of mealtimes. During the inspection, staff we spoke with confirmed that out of hours patients had access to hot and cold snack food choices. Soft diet choices of porridge, soup and yogurts were available as well as hot and cold drinks.
- Since the 2014 inspection the trust had implemented hydration stations to provide hot drinks and soup 24 hours a day. Although we saw these trolleys were on wards visited, it was not clear that these were for patients to use. The trust confirmed that these were operated by staff when patients requested additional drinks.
- The Malnutrition Universal Screening Tool (MUST) was used within the trust to identify adults who were at risk of malnourishment. MUST nutritional assessments were recorded on the WEB V computer system and an action prompted response was required on a weekly basis to review the assessment.
- Although some patients told us the quality of food was poor, most patients we spoke with said it was acceptable. We reviewed patient led assessment of the care environment (PLACE) results and noted that the food was scored at 86.09% against a national average of 88.49%. Although slightly lower than the national average, this score was an improvement on the 57.7% score within the 2014 inspection report.

Patient outcomes

- In 2014, we asked the trust to ensure there was an improvement in the number of patients with fractured neck of femur who received surgery within 48 hours. At the time of the 2014 inspection 71.4% of fractured neck of femur patients had surgery within 48 hours at this hospital compared to the England average which was 87.3% during 2013.
- National hip fracture audit data for 2014 showed SGH performed better than the England average on most of the indicators. However, there had been deterioration in performance at SGH in six of the areas reported on in 2014 compared to 2013 including the proportion of patients having surgery on the day or after the day of admission which was lower (64.9%) than the England average (73.8%) and lower than 2013 (71.4%).
- There was conflicting evidence with the range of compliance with this target. The internal trust performance dashboard indicated that the best practice tariff target for patients with fractured neck of femur having surgery within 36 hours was 100%. This data showed that the trust only met this on approximately 20% of occasions between March 2015 and May 2015.
- We reviewed the neck of femur action plan and saw a different internal target for patients having surgery within 36 hours, which was 75%. The action plan indicated that in May 2015 compliance was 61.4%, yet the performance dashboard we reviewed for May 2015 showed compliance at 15%. We discussed performance

against the 36-hour target with the senior management team and an action plan had been developed toidentify why patients were not having surgery within the first 36 hours.
- We reviewed the organisational plan and saw that one of the priorities was to reduce surgery-related harm (moderate and above), occurring in the trust across all surgical specialities, with a particular focus on harm in orthopaedic surgery. It stated this was to be delivered by fostering a good safety culture, better teamwork and by building a pro-active safety measurement and monitoring framework that supports a continuous learning culture.
- The trust continued to contribute to all national surgical audits and we noted good performance in both the bowel and lung cancer national audits.
- We found the National Emergency Laparotomy audit 2014 showed that 15 out of the 28 measures were not available. For the 2015 patient audit results, the hospital scored 6 out of 11 measures as red.
- The trust participation rate and outcomes for the patient reported outcomes (PROMS) measures showed similar performance to other hospitals.
- Elective and non-elective urology and colorectal surgery and general surgery had a lower risk of readmission against the England average between December 2013 and February 2015. Elective urology had a lower risk of readmission, however, general surgery had an increased risk of re-admission, nearly 50% greater than the England average for the period December 2013 and February 2015. Non elective surgery remained below or about the same as the England average between December 2013 and February 2015; however trauma and orthopaedics were increased.

Competent staff

- In 2014, following the CQC inspection, the trust was asked to ensure that staff have appropriate appraisal and supervision. In 2014 compliance rates for nursing staff having appraisals varied between wards and theatres from 49% up to 91%.The trust had an internal target to achieve 95% compliance for appraisals by April 2014.
- Appraisal records we reviewed for April 2015 to November 2015 showed that 69% (428/623) of staff within surgical areas had received an appraisal. Wards had achieved overall 82%; however, some wards had individual compliance lower than 50%. Within the theatre environment, 49% of staff had received an appraisal.
- When nursing appraisals had taken place it was not always evident where training needs had been actioned. Pre-assessment staff we spoke to told us that no funding was available to allow them to attend a pre-assessment training course.
- National guidance recommends that medical staff have an appraisal at least once a year. In 2014 appraisal rates were 56% to 100%. Records we reviewed during this inspection indicated that in 2015 appraisal rates for medical staff were approximately 95% compliant.
- There were policies to ensure bank and agency nurses were competent and aware of key requirements; the nurse in charge of a shift on a ward should use an induction checklist for bank and agency staff. The trust provided us with some completed checklists. However, at the unannounced inspection we also observed on at least two occasions that this had not been completed due to work pressures.
- Newly appointed staff underwent an induction process and spent time at a “care camp” a two-week classroom based training programme. They also had a period of supernumerary status on the ward. New starters we spoke to told us about comprehensive induction packages.
- The acute pain team had undergone extra training to allow them to prescribe pain relief during working hours. This extra skill helped patients to receive pain relief in a more timely fashion, rather than having to wait for medical staff to prescribe.

Multidisciplinary working

- Staff spoke to us about positive working relationships within the surgical areas.
- Pharmacists, physiotherapists and occupational therapists visited the wards Monday to Friday. We observed discussions between members of the MDT and they appeared clear, appropriate and knowledgeable.

Seven-day services

- Routine surgery was performed Monday to Friday, with emergency surgery being performed seven days a week.

- Physiotherapy, imaging services and pharmacy provision was available on an out of hours on-call basis, seven days a week.
- Junior medical staff were available 24 hours a day on site, consultants were on-call on a roster system, and on-call rotas were available for other key staff out of hours.

Access to information

- National recognised patient administration systems were in use providing access to patient administration, booking, radiology and pathology services.
- A new virtual ward patient administration system had been developed and launched within the trust in the previous year. This system alerted staff and recorded when patient observations were due. It gave access to test results and could be used as a bed management system. The functionality was displayed on large screens within the nurse base of a ward area and allowed staff to easily view details of a patient's care. Icons were highly visible on the system showing assessments that had been carried out. One notable highlight was the ability to take and store a picture of a patient and store them during the admission, in case of patient identification issues.
- A process was in place to provide agency staff with passwords for the computer system; however, staff did talk to us about this process not always working due to the workload of the staff involved. Staff also told us that on occasions, agency staff place pressure on substantive staff to share passwords, non-supply of passwords increased the workload of substantive staff due to having to record all observations on the system for the agency worker. Information governance and safety risks were also increased if staff shared passwords, or inputted observations taken by other staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent from patients was gained via both verbal and non-verbal routes. The staff we spoke to were aware of how to gain both written and verbal consent from patients and their representatives.
- Consultant medical staff sought consent from patients prior to operations or procedures. Junior medical staff were able to gain consent from patients on completion of a consent passport for individual procedures. We noted specific consent forms within ophthalmology; these were specific to the type of surgery being performed and had risks identified. These could be signed by a nurse specialist.
- Where patients lacked capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative), who could legally make those decisions on behalf of the patient.
- Staff we spoke with were able to describe their responsibilities in relation to the legal requirements of the Mental Capacity Act (MCA) 2005.
- Deprivation of Liberty Safeguards (DoLS) training compliance data for the Surgical group was reviewed and were noted to be 85%, against a trust target of 95%.

Are surgery services caring?

Good

We rated surgery as 'good' for caring because:

- We observed positive caring interactions with staff on the wards. Staff in the theatre suite were caring and providing good levels of communication and reassurance to patients. We saw staff communicating well with patients and putting them at ease.
- Patients were mainly well supported and treated with dignity and respect; however, there were times when patients did not feel well supported or cared for, they told us this was because of staff shortages.

Compassionate care

- We spoke to 25 patients over four wards. On wards 10, 11 and 28 nine patients spoke about negative aspects of care, themes were poor communication and staffing levels.
- On two other wards we visited all seven patients we spoke with told us that staff were "lovely, kind, caring" towards patients and provided reassurance. However they felt that there wasn't enough staff to let them care and that patients had to wait for care.
- When we observed staff going about their work, we saw positive interactions. Staff in the theatre suite were caring and providing good levels of communication and reassurance to patients. We saw staff communicating well with patients and putting them at ease.

Surgery

- We reviewed PLACE assessments for privacy, dignity and wellbeing and noted that the trust scored 87.25% against the England average of 86.03%.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients satisfaction with the healthcare they have received. It was noted that the response rate of 43.7% was higher than the England average of 36.5% and generally, there was a higher proportion of surgical patients who would recommend the service.

Understanding and involvement of and those close to them

- Most patients we spoke to, said that they felt they had been involved in their care decisions and risks and benefits of surgery had been discussed with them. Three patients told us they were unhappy with the information they received prior to and during their procedure.
- Most patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.

Emotional support

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

Are surgery services responsive?

Requires improvement

We have rated surgery as 'requires improvement' for responsive because:

- Services did not always meet people's needs. Patients were not always able to access services for assessment, diagnosis or treatment when they needed to. There were long waiting times, especially in urology, pain procedures, ophthalmology and trauma and orthopaedics.
- Patients were experiencing delays and cancellations of operations and procedures. Actions taken to address delays or cancellations were not always taken in a timely or effective manner. A high level of medical outliers was observed in surgical beds.

However,

- Staff could describe their roles in relation to complaints management were aware of the number of complaints and the themes received for their area.

Service planning and delivery to meet the needs of local people

- Most services were commissioned by the two local clinical commissioning groups.
- There was an ongoing strategic review of the configuration and sustainability of health and social care services across the geography of North and North East Lincolnshire called "Healthy Lives, Healthy Futures".
- There had been reviews of some surgical services for example Ear Nose and Throat (ENT) and Ophthalmology and theatres. These had identified information about the number of surgical procedures which were required to meet the referral demand. The senior management team spoke with us about the challenge of implementing the recommendations due to issues with physical space available, availability of staff, and balancing of job plans.The senior medical team were unaware of how many pre-assessment appointments were required to assess correctly the number of patients being referred. They were also unaware of the length of time each operation required and whether enough theatre time was available.
- Recent information supplied by the trust in January 2015 indicated that a nursing establishment review had been undertaken across all sites on surgical wards. The recommendations were for an improved nursing establishment on wards B4, B6 and B7 at DPoW.

Access and flow

- The target Referral to Treatment Time (RTT) is set within the NHS at 18 weeks from referral from general practitioner to treatment time. Since July 2014, RTT performance has been generally below the 90% standard, data reviewed for May 2015 showed improved performance, at 92%. The England average performance during the same time period had also been below the standard. ENT, Trauma and Orthopaedics, and Ophthalmology specialities provided at the trust did not meet the standard.
- The percentage of patients (with all cancers) waiting less than the set target times of 14, 31 and 62 days from urgent GP referral to first definitive treatment was 97.2%

for14 day treatment in Sept 2015 which wass higher than the 93% England average for the same period. It was 100% for 31-day treatment in Sept 2015, again higher than the 96% England average for the same period and 84.8% for 62-day treatment in Sept 2015, slightly higher than the 84% England average. However urology and gastrointestinal cancer referrals at the trust did not meet the 85% target in March or April 2015.

- Theatre utilisation data was reviewed and noted to be at 84.5% April to June 2015; with 47% of operating lists overrunning between November 2013 and October 2014.
- The trust had commissioned an external consultancy company to investigate efficiency and productivity within theatres. This work identified a number of areas where improvements could be made from both a quality/patient experience and financial benefit perspective. A theatre efficiency action plan we reviewed, was detailed as to the issues, and identified timescales for completion.
- There was a high 'on the day' cancellation rate of around 9%. We reviewed current on the day cancellation data supplied to us by the trust; 240 patients were cancelled for clinical reasons and 180 for non-clinical reasons from March 2015 to May 2015. High rates of patient cancellations, both clinical and non-clinical, showed issues within bed management, pre assessment and patient flow within the surgical area.
- The average length of stay in the trust for elective surgery was slightly worse 3.3 days compared to the England average 3.1 days between December 2013 and February 2015. General surgery elective admissions had the greatest length of stay at 5.0 days. Non-elective trauma and orthopaedic admissions were better than the England average with 4.7 days trust length of stay versus 8.5 days England average. Elective urology had a lower risk of readmission, however, general surgery had an increased risk of readmission, nearly 50% greater than the England average December 2013 and February 2015.
- Consultant listing and pre-assessment of patients was not always appropriate as many patients were listed as day cases then converted on admission, prior to operation, to overnight stays. This unplanned approach made bed management difficult and could increase stress on patients. Staff and the theatre lists we reviewed corroborated this view. Staff all spoke to us about the order of lists often been inappropriate and gave examples of complex cases with multiple morbidities having beenlisted as day cases and then converting to overnight admission.

Meeting people's individual needs

- Following the 2014 inspection, the trust was asked to review access to British Sign Language interpreters (BSL). Staff we spoke to confirmed they knew how to ask for interpreters.
- In the previous year, specially adapted rooms had been developed to care for patients who were living with dementia. They had been designed with a specific colour scheme, low-level beds, facilities to have music playing, and dementia friendly equipment was supplied in the bays.
- Staff we spoke with were all very proud of these rooms; however, staff expressed the view that patients living with dementia were often moved out of these specially adapted rooms to other ward areas non-dementia friendly environments due to the bed pressures within the hospital. They felt that moving patients living with dementia was upsetting to the patient and relatives and led to a poor experience of care. We witnessed patients with dementia being moved out of these specific rooms and being transferred to other areas during the inspection.
- Although dementia training was available as a training module, staff expressed to us that not enough spaces were available to attend this training. One of the quality matrons was designated as lead for dementia within the trust; however, this nurse also was the lead for learning disability. A specific nurse specialist was not available to support dementia care within the trust.
- Staff we spoke to within the day case unit were clear about the care required for patients with learning difficulties (LD). Where possible there were specific lists for operations for patients with LD. Staff told us this allowed greater support for these patients and relatives.
- There were patient feedback boards on the wards; "you said, we did" boards. One of these boards detailed feedback from patients. Some of the feedback we observed was about a day room being drab and uncomfortable, action taken by the trust was that new chairs had been purchased, however during the inspection we visited this area and felt that it was not patient friendly. Another board was feedback about

being taken off the ward for tests during visiting times; the trust had taken action by adding longer time onto the visiting time for these at the ward manager's discretion.
- The four bedded high observation bay (HOB) on ward 28 had a mix of male/female patients when we inspected. The bed spaces offered minimal privacy and dignity due to the small size of the room.

Learning from complaints and concerns

- Data supplied to us from the trust showed us that within the surgery group there were 28 current open complaints from the period of September 2014 to August 2015. Some of these complaints had been open since January 2015 and the completion date had been renegotiated on three occasions.
- Themes of these complaints included all aspects of care (19/28), failures in communication (4/28) and issues with admission, discharge arrangements (3/28). Data we reviewed supplied by the trust showed that the surgery group was achieving 100% complaints investigated and agreed with complainant in timescale during April 2014 to April 2015.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patient or relatives as required. Senior staff we spoke to were aware of the number of complaints and the themes received for their area.

Are surgery services well-led?

Requires improvement

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

- The delivery of high quality surgical care was not assured; there was no overarching surgical strategy or vision. Whilst there were plans in place for some specialities there was no process in place to review overall surgical strategy and individual strategies competed against each other for priority. We were told that some of the future service provision would be determined through the ongoing local health community "Healthy Lives, Healthy Futures" work stream. Risk issues were not always dealt with in a timely or appropriate way.
- Leadership was variable; we saw improved leadership on surgical wards from ward managers. It was noted in the 2014 inspection, that the senior management team was new at that time and had not had time to implement changes. The senior management team had also been changed again within 2015, with a new Assistant Chief Operating Officer, and various clinical leaders. Managers had not yet identified, prioritised and taken action on all of the issues of concern within surgery. . The development of the Web V virtual ward administration computer system had made an impact on the documentation of patient risks.
- Improvements from the introduction of the quality and safety days were still to be embedded.

Vision and strategy for this service

- Strategic documents had been developed for individual surgical specialities such as theatre, breast, ENT and Ophthalmology.
- No overarching surgical strategy was available, encompassing all surgical specialities, so it was difficult to identify the top priorities within surgery.
- We were told that some of the future service provision would be determined through the ongoing local health community "Healthy Lives, Healthy Futures" work stream. Individual ward visions were available in some areas.
- No specific surgery group vision was available.
- There was a trust operational plan for 2015-16 which included some speciality surgical plans but was not a comprehensive plan for surgery.

Governance, risk management and quality measurement

- Since the last inspection, a bi-monthly joint cross-site MDT quality and safety meeting had been introduced and three meetings of the group held. All surgical staff were invited to attend and emergency cover was provided in surgery during these meetings. We reviewed two sets of meeting minutes and noted good attendance and a well-organised, informative meeting, sharing current clinical information. At one of these meetings a clinician had presented the outcome of a never event.

Surgery

- We reviewed individual sets of governance meeting minutes for speciality services and noticed varying levels of attendance. Key themes around incidents, complaints and lessons learnt were not always discussed.
- We reviewed two sets of surgical and critical care governance meetings minutes and noted good attendance and good documented discussion of incidents, complaints and serious incident investigations (SI). However, many front line staff told us they did always get individual feedback and learning from incident reviews.
- Performance was reported using a monthly dashboard which showed rates of pressure ulcers, mandatory training and other performance data.
- Risk registers were reviewed and we noted that risks dated back to 2005, some with little or no apparent action. Examples of risks included provision of equipment, ophthalmology, storage and staffing. It was unclear from the register what controls were inplace to mitigate some of the risks or the rationale for the grading of the risks. For example the ophthalmology services was initially graded as a moderate risk yet there had been known cases of harm to patients, and following actions being taken it remained at the same grade.
- The senior management team said that balancing activity, ward and department staffing and finance were their top challenges.

Leadership of service

- In early 2014, the clinical leadership structure had been changed with the intention of improving accountability and governance. During this inspection all staff we spoke to were aware of the leadership structure. The senior management team had also been changed again within 2015, with a new Assistant Chief Operating Officer and various clinical leaders. These changes meant there had been a lack of focussed leadership and the issues of concern within surgery had not yet been fully identified, prioritised and acted upon.
- The leadership team had been through a huge amount of change in the previous year; many wards had a new ward manager and although most of the new leaders had made a positive impact on leadership in their areas, the leadership team required more time for the impact of the changes to be sustained.
- Staff we spoke to working on the SGH site were not always aware of their colleagues working in DPoW in the same areas. This could hamper sharing lessons learned from incidents and complaints, especially as the trust has two sites providing a similar service. Cross-site working (working in all hospitals belonging to the trust) and joint meetings for some medical and senior staff had only recently been introduced.
- Nursing staff spoke positively about colleagues and their management structures. Four matrons supported the surgical area. One area we visited said that they did not know who their matron was and said the matron had never visited. A 'Clinical Friday' had been developed which was an initiative where all matrons worked on the wards.
- Some senior nurse meetings were held across both sites.
- One area we visited had set up a private group page on social media and was using this to share key messages to staff.
- We received positive comments about the leadership within theatres.

Culture within the service

- Staff morale within surgical areas of the hospital was mixed. All staff we spoke with were positive about colleagues, they spoke about the environment being patient focused, and an open and honest culture. However, staff said they felt deflated due to the staffing levels. Staff we spoke to said they were proud of their teams and their colleagues.
- Staff within theatres spoke of a positive culture which we observed; staff were supportive and mutual respect was shown to each other.
- Students we spoke to, felt supported in their roles during placements.
- Staff we spoke to, told us that the senior management was not visible on the wards or departments; however, the senior management team told us that they were conducting walk rounds.
- Staff we spoke to, all said they felt able to raise concerns.
- Staff told ustheir biggest worries were staffing, documentation changes, and they felt like tasks they were undertaking were rushed. When we asked staff how they could improve the care they provided, they said improved staffing so more time could be spent with patients, and that the buildings required improvement.

Surgery

Public engagement

- We saw notice boards on the wards displaying 'you said we did' information with details of how the ward had responded to feedback from patients. One example was how a ward had used this feedback was patients had said that the day room was drab and uncomfortable; actions taken by the ward was topurchase new chairs. Another ward detailed feedback about patients being taken off the ward for tests during visiting times; the ward had taken action by adding longer time onto the visiting time for these patients at the ward manager's discretion.

Staff engagement

- Weekly newsletters were produced for staff; open forums with general managers and the chief executive were in place. However, many staff felt engagement could be improved, especially when changing staff roles and / or services.
- Ward managers also spoke about an 'open door policy' for staff to discuss issues with them.

Innovation, improvement and sustainability

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

Critical care

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

Information about the service

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

The intensive therapy unit (ITU) at SGH had eight beds, six in an open bay and two side rooms. It was staffed to care for six level three patients (who require advanced respiratory support or a minimum of two organ support) and two level two patients (who require pre-operative optimisation, extended post-operative care or single organ support). Intensive Care National Audit and Research Centre (ICNARC) data showed that between April 2014 and March 2015 there were 437 admissions with an average age of 63 years. Sixty nine percent of patients were non-surgical, 13% elective surgical and 18% emergency surgical. The average length of stay on ITU was five days.

During the inspection we visited ITU. We spoke with two patients, four relatives and 21 members of staff. We observed staff deliver care, looked at six patient records and two medication charts. We observed nursing and medical handovers. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

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

Critical care

Summary of findings

Overall, we rated critical care as 'requires improvement'. Safe, effective, responsive and well-led we rated as 'requires improvement' and caring was rated as 'good'. There was no improvement in the ratings from the 2014 inspection to this inspection.

- Essential critical care equipment such as beds, mattresses and ventilators was old and described by staff as not fit for purpose. This had been added to the surgery and critical care risk register in 2009. There was no evidence that any action had been taken and funding was not available for replacement in 2015/16 capital program.
- Twenty eight pieces of equipment required for direct patient care were out of date. Oxygen cylinders were not stored in line with national guidance.
- The unit did not meet the requirements of national standards for nurse or medical staffing. A consultant intensivist was not available seven days and week and medical staff rotas did not promote continuity of care. A supernumerary senior nurse was not available 100% of the time as a clinical coordinator. The clinical educator post had been vacant for eighteen months at the time of our inspection.
- Patient outcome data for the ITU was variable; the mortality ratio was worse than the critical care network average data.
- Staff showed limited application of putting policies into clinical practice, for example, patient consent and restraint.
- The bed occupancy was higher than the national average. The number of delayed discharges was higher than the critical care network average. Staff reported 10 incidents of mixed sex accommodation occurrences due to delayed discharges. Forty two elective operations were cancelled due to a lack of critical care bed and 46 patients were ventilated outside the unit. There were eight non-clinical transfers in the six months prior to our inspection This was not in line with recommendations from Core Standards for Intensive Care (2013).
- The management team had not taken timely action on some of the issues identified on the risk register. Ageing and failing equipment that had an effect on patient and staff safety within ITU such as beds and ventilators had been on the risk register for up to six years. From the records of the service governance meetings we saw little evidence to suggest leaders reviewed the risk register or developed actions to mitigate risk.
- Morale varied across staff groups with themes being around changes to clinical leadership and working patterns

However,

- Recent changes had been made to the clinical leadership and time was needed to engage all staff in the changes and embed the new structure of leadership.
- Some progress had been made to cross site working and standardisation of evidence based care across both sites.

Critical care

Are critical care services safe?

Requires improvement

We rated the service as 'requires improvement' for safe because:

- Staff in the critical care outreach team did not consistently receive feedback from incidents because they worked across all directorates.
- Essential critical care equipment such as beds, mattresses and ventilators was described by staff as not fit for purpose. There was evidence of failure of the equipment reported as incidents.
- We found out of date consumables required for direct patient care in the equipment store. The storage of oxygen cylinders was not in line with national guidance.
- Nurse staffing was not in line with Core Standards for Intensive Care (2013). The trust provided copies of the rota for ITU. During August 2015 the actual number of staff on was lower than the planned number on 10 shifts. This meant there may not have been a supernumerary coordinator on the unit on these shifts. The unit's nursing establishment was 39 WTE, less than seven of these posts were senior nurses (Band six or above). The unit had a limited infrastructure of support staff. It did not have a ward clerk or equipment technician meaning clinical staff had additional tasks.
- The unit did not meet the requirements of the Core Standards for Intensive Care (2013) for medical staffing, for example, twice daily ward rounds did not take place at the weekend and consultant work patterns did not deliver continuity of care as the consultants covered one day at a time. Out of hours junior medical staff covered ITU, theatre, wards and ED referrals and obstetrics. Staff acknowledged the potential for delay in care and a change to the rota was planned in the critical care strategy.

However,

- The unit was visibly clean and we saw evidence of regular infection prevention and control audits.
- Mandatory training was above the trust target.

Incidents

- There were no never events reported between August 2014 and July 2015
- There was one serious incident reported between September 2014 to August 2015, this had been reported to the Health and Safety Executive, investigated by the trust and an action plan had been developed.
- During our inspection in 2014 we found incident reporting to be higher in this ITU than at DPOW ITU this was still the case at this inspection. There was also a difference in the grading of incidents between both units. This unit reported 154 incidents between September 2014 and August 2015, 97% of these were graded as very low and 3% low. Themes of the incidents were skin and pressure damage, delayed and out of hours discharges and agitated or unsettled patients.
- All staff were able to tell us how to report an incident and the themes of the incidents reported. Staff received feedback from managers directly, through the communication board in the staff room and the trust newsletter for incidents that had occurred outside of the directorate. A junior doctor gave us an example of support and feedback they received after reporting an inappropriate referral.
- Staff in the critical care outreach team who follow-up patients when they are discharged from ITU to the wards expressed concerns that they did not consistently receive feedback from incidents as they worked across all directorates. The team were not based on or near the unit. The nurse consultant that managed the critical care outreach team had introduced a cross site critical care outreach meeting where critical care outreach staff discussed case studies and formulated an action plan. The nurse consultant shared this with the Heads of Nursing.
- Serious incidents and a mortality review were discussed at the bi-monthly surgery and critical care quality and safety day. There was no multi professional critical care specific morbidity and mortality meeting which was not in line with the Core Standards for Intensive Care (2013). In the minutes of the critical care provision group meetings in June and July 2015 the clinical lead suggested a monthly mortality and morbidity meeting should be held on each site.

Duty of Candour

- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or significant harm.

Critical care

- Senior staff clearly understood the duty of candour, a consultant gave us an example of an incident they had reported and met with the family to discuss it. This was to be presented at the quality and safety day to share the learning.
- Following an incident that involved moderate harm, a letter was sent to the family with contact details of a matron who would be responsible to liaise with the family throughout the investigation.

Safety thermometer

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

Cleanliness, infection control and hygiene

- The unit was visibly clean.
- The unit had not had a case of clostridium difficile for 1000 days.
- The unit had not had a unit acquired methicillin resistant staphylococcus aureus infection between April 2014 and March 2015.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Training participation information provided by the trust showed 84% of nursing staff and 67% of medical staff in the surgery and critical care directorate had completed infection control training.
- Results from monthly hand hygiene audits between January and July 2015 showed 100% compliance.
- Results from the MRSA policy to practice audit between January and July 2015 showed 100% compliance.
- The position of the clinical handwashing sinks had improved following the refurbishment of the unit.
- The unit had facilities for respiratory isolation.

Environment and equipment

- The unit was secure; access was via an intercom with a security camera.
- The unit had been refurbished since our inspection in 2014. Bed spaces were clear, unobstructed and uncluttered.
- There was an adjoining corridor from the unit to the operating theatres.
- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. The bed spaces were separated by curtains to maintain patients' privacy.
- Equipment was visibly clean and was labelled with the date it had been cleaned and an initial of the staff member who had cleaned it.
- Nursing dashboard and quality dashboard environmental audit results were between 99% and 100%.
- Daily sink flushing records were complete.
- The shift check compliance record had not been completed on six out of 17 occasions.
- Staff checked the defibrillator daily. Records showed this had not been done on four out of 15 days in the month of our inspection.
- We found 28 out of date consumables in the equipment store. The consumables were required for direct patient care, for example, suction catheters, artificial airways (endotracheal tubes) and invasive devices (central venous catheters). The expiry dates were from earlier in 2015.
- The ageing beds on the unit had been on the risk register since 2009. Staff told us they were not fit for purpose as they did not have the ability to weigh patients and frequently broke down. Incident reporting data submitted by the trust supported this.
- The unit had a limited supply of air mattresses. Staff told us the process for cleaning the mattresses had improved but there was still a risk that sufficient would be available to patients. This had been on the risk register since 2013.
- Two commercial baby monitors which had visual and sound capability but no recording capacity were in use in the side rooms. The screen was located at the nurses' station and could not be viewed from anywhere else. Staff told us one of the reasons for the use of the monitors was staff safety; in case staff in the room needed assistance and were not able to reach the emergency call bell.

Critical care

Medicines

- Medicines were stored appropriately. Staff checked fridge temperatures daily. Records were complete and temperatures were within the recommended limits. Staff only recorded the current fridge temperature not the minimum or maximum temperature of the fridge. This was not in line with national guidance.
- Five oxygen cylinders were stored in the stationery cupboard. There was no signage on the door to indicate medical gases were inside. The stationery cupboard also contained cleaning products, some of which contained alcohol, for example, hand sanitiser, hydrex pink and hard surface spray. We raised concerns about this with the nurse in charge who was unsure if a risk assessment had been completed for this storage. This was not included on the unit or pharmacy risk register.
- The unit achieved 90% compliance on the trust-wide re-audit of safe and secure handling of medicines.
- There had been five medication errors reported on the unit between April 2014 and March 2015. This was less than 1% of medication errors reported at SGH.
- A notice board on the unit displayed information on medicines management.
- In addition to the trust medication administration record (MAR) there was a separate ITU MAR with pre-printed drug regimes. This had recently been introduced, staff were concerned there was the potential for medicines to be missed. There was no evidence that this had occurred or been reported as an incident.
- We reviewed two MARs that were complete; however, not all antibiotics had an indication or review date documented on. A microbiologist visited the unit daily between Monday and Friday, staff told us this was when antibiotics were reviewed but there was no evidence of the review on the MAR chart.

Records

- We reviewed six sets of both medical and nursing records. They were all accurate, complete and in line with Core Standards for Intensive Care (2013) and professional GMC and NMC standards.
- Medical staff completed a daily critical care assessment proforma that met the National Institute of Health and Care Excellence (NICE) CG50 guidance (acutely ill adults in hospital; recognition and response to acute illness in adults in hospitals).
- Doctors completed a medical discharge summary that accompanied the patient to the ward on discharge from the ITU.
- We requested evidence of local documentation audits from the trust but none were submitted. This meant we were unable to assess the quality and standard of the completion of records across the service.

Safeguarding

- All staff we spoke to were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns. Staff knew how to access to trust's safeguarding policy and the safeguarding team.
- Ninety eight percent of nursing staff and 91% of medical staff had completed safeguarding adults training.
- One hundred percent of nursing staff had completed safeguarding children level one and level two training. No nursing staff in the service had completed safeguarding children level three training. Ninety seven percent of medical staff had completed safeguarding children level one training and 91% level two training. One hundred percent of medical staff had completed safeguarding children level three training.

Mandatory training

- Mandatory training included moving and handling, resuscitation training and fire training.
- Information provided by the trust showed that 98% of nursing staff on ITU and 95% of nursing staff in the critical care outreach team had received mandatory training. The trust target is 95%.
- We saw evidence that medical staff's mandatory training was up to date.

Assessing and responding to patient risk

- The critical care outreach team provided a service from 07:30 to 20:00 seven days a week. The hospital at night team managed patients outside of these hours.
- Information provided by the trust showed the critical care outreach team received 800 referrals in the last twelve months.
- A nurse consultant had recently been appointed in the deteriorating patient team. The critical care outreach team were part of this team as was a sepsis nurse and a vascular access nurse.

- The trust used a recognised national early warning tool called NEWS which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- All the risk assessments were completed in the six records we reviewed. These included falls, moving and handling, nutrition, tissue viability and VTE.

Nursing staffing

- Nurse staffing met the Core Standards for Intensive Care (2013) minimum requirements of a one to one nurse to patient ratio for level three patients and a one to two nurse to patient ratio for level two patients.
- The unit displayed the planned and actual staffing figures.
- The unit had an establishment of two WTE band seven, 4.67 WTE band six and 32.32 WTE band five registered nurses. This meant that at times band five nurses managed the unit, this was included in the band five job description. Senior staff thought this wasimportant as part of the band five development.
- There was one WTE band seven vacancy and 0.05 WTE band five vacancy. One WTE band two worked on the unit.
- The trust provided copies of the unit rota; during August 2015 the actual number of staff was lower than the planned number on 10 shifts.
- The establishment had been increased to include a supernumerary coordinator 50% of the time seven days a week. Additional staffing had been included in the business case for the High Dependency Unit (HDU) expansion to meet the Core Standards for Intensive Care (2013) supernumerary coordinator requirement 100% of the time.
- The unit had used agency staff less than 10 times in the last year. The trust used an agency that supplied staff that were critical care trained.
- The trust offered staff who work in specialist areas a financial incentive to work on the nurse bank. During our unannounced inspection on 6 November 2015 we reviewed the nursing rota for two weeks from 26 October 2015. Bank staff had covered twelve shifts.
- New staff and students completed an induction; we saw evidence of completed induction checklists.
- We observed a handover where clear patient information was provided and any unit issues were discussed, for example, staff sickness, equipment or expected admissions. The nurse in charge allocated nurses to patients and considered continuity of care and the experience of the staff.
- The audit clerk attended the morning handover; this ensured data collection was robust.

Medical staffing

- Sixteen consultants covered the unit, five of these were intensivists. A consultant was based on the unit between 08:00 and 21:00 Monday to Friday and available on call within 30 minutes out of hours. A second on call anaesthetist was on site 24 hours a day, seven days a week.
- The unit did not meet the requirements of the Core Standards for Intensive Care (2013) for medical staffing, for example, twice daily ward rounds did not take place at the weekend and consultant work patterns did not deliver continuity of care as the consultants covered one day at a time.
- Out of hours two junior medical staff were on site. One was responsible for theatre and the other one covered ITU, ward and ED referrals and obstetrics. They were supported by a consultant on call who was available within 30 minutes. One doctor gave an example of their workload overnight that included two obstetric calls, one theatre case, one ED and one ward referral and ITU patients that required a review.
- Staff acknowledged the potential for delay in care and a change to the rota was planned in the critical care strategy. Junior medical staff told us they felt supported by the consultant on call.
- The consultant to patient ratio did not exceed the range of 1:8 or 1:15, which was in line with Core Standards for Intensive Care (2013).
- There was a named lead consultant for induction. Junior medical staff explained the induction process in the department, equipment, role and educational supervisors.
- Operating department practitioners supported the medical staff on ITU.
- We observed a medical handover; this took place in the doctor's office, was structured and included a discussion about patients on the unit and referrals received from elsewhere in the hospital. An electronic handover system was used that ensured information was shared and a record was kept of when the handover took place and who was in attendance.

Critical care

Other staffing

- The unit had a limited infrastructure of support staff. There was not a ward clerk or an equipment technician. This meant that clinical staff had additional tasks to complete, for example, filing of notes in the patient record and reporting equipment faults.
- Additional hours for audit clerks had been allocated, the posts had been recruited to and staff were awaiting a start date.

Major incident awareness and training

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

Are critical care services effective?

Requires improvement

We rated the service as 'requires improvement' for effectiveness because:

- Patient outcome data for the ITU was variable; the standardised mortality ratio was 1.16, worse than the critical care network average data.
- The service did not have a clinical educator which was not in line with Core Standards for Intensive Care (2013). The post had been vacant for eighteen months. This meant new staff had limited study daysThere was a lack of evidence of putting knowledge of policy into practice, for example, staff awareness of the restraint policy and the use of mittens for patient safety.
- Staff used a baby monitor to observe at the nurses station patients in both of the side rooms. Staff showed limited understanding of the need to obtain consent from patients and relatives for the use of the monitor. Staff did not record whether patients gave consent.

However,

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

Evidence-based care and treatment

- Critical care policies and guidelines were in the process of being reviewed and standardised across site. Staff were aware of the Core Standards for Intensive Care (2013) and there was evidence that the reviewed policies and guidelines were based on up to date best practice.
- The clinical lead showed us a timetable for the planned review of out of date guidelines. The critical care website had been updated and new guidelines that had been produced, for example, protective ventilation was available on there.
- We reviewed a draft copy of the new policy for pain, agitation, delirium and sedation that was based on NICE and other relevant guidance. At the time of our inspection staff did not complete delirium screening.
- The policy for children and young people requiring ICU/HDU at SGH and DPOW had been updated in 2014 and was based on current evidence.
- We observed a ward round. Staff completed a structured system based assessment of the patient which included a review of care bundles and ventilation parameters. A checklist was not used on the ward round but the plan was clearly communicated to the patient and staff and documented on the daily assessment form.
- Physiotherapists completed rehabilitation assessments and produced a treatment plan but there was limited evidence of awareness and compliance with NICE CG83 rehabilitation after critical illness by all staff on the unit.

Pain relief

- We reviewed patient records and observed staff assessing pain and giving support to patients requiring pain relief.
- One of the patients we spoke to reported good assessment and management of their pain.

Nutrition and hydration

- Nurses completed a nutritional assessment using the recognised malnutrition universal screening tool (MUST). Staff had to estimate the body mass index range

using the mid upper arm circumference measure as the beds did not have the facility to weigh. The nutritional assessments were up to date in the six records we reviewed.
- A dietician visited the unit daily but did not attend the ward round. There was evidence of communication of nutritional plans in the patient record.

Patient outcomes

- We reviewed the ICNARC data for the ITU from 1 April 2014 to 31 March 2015. The standardised mortality ratio was 1.16; this was higher than other units in the critical care network but within the acceptable range. The crude mortality was 19% which was higher than the critical care network average.
- There was six early readmissions between 1 April 2014 and 31 March 2015, this was 2% of all admissions and was in line with the critical care network average.
- The audit lead showed us evidence of the audit register. The service participated in the national tracheostomy audit, the national cardiac arrest audit and the national emergency laparotomy audit. Reports were being compiled or presentations were pending, so action plans were not yet available.
- The critical care outreach team collected patient outcomes in the trust electronic database, Wardwatcher.
- There was no evidence of participation in the network audit of compliance with NICE CG83 rehabilitation after critical illness.

Competent staff

- All medical and nursing staff we spoke to told us they had received an appraisal within the last 12 months. We saw evidence that 100% of nursing appraisals had been completed and we reviewed appraisals in three staff files. The appraisals were completed in a structured way following the trust guidance.
- Staff participated in clinical supervision. Records showed 87% of staff had supervision. We reviewed records of this in three staff files. A member of staff gave us an example of when group supervision had taken place following an incident that had affected staff emotionally.
- Senior staff encouraged nurses to register for Nursing and Midwifery Council revalidation and were awaiting the appointment of a trust lead for further guidance.
- Fifty eight percent of nurses had completed a post registration critical care qualification. This was above the minimum recommendation of 50%.
- New members of nursing staff received an induction, were allocated a mentor and had a supernumerary period of between four and eight weeks depending upon their previous experience.
- Nurses completed a local competency package. This was based on the national competency framework for adult critical care nurses.
- The clinical educator post had been vacant since April 2014. Staff and the management team all told us that this role was missed on the unit and recruitment into it was a priority. Information for staff on the education board was out of date, the link nurse roles displayed were dated 2011 and 57% of the courses advertised were out of date.
- Staff in the critical care outreach team were involved in education in the trust. They delivered training on non-invasive ventilation, suction and tracheostomies and were a centre for the ALERT and BEACH courses (multi-professional courses that train staff in recognition of patient deterioration and actions to treat the acutely unwell).
- Junior medical staff told us they met with their educational supervisor and had ITU specific education sessions based on the Royal College of Anaesthetists and Faculty of Intensive Care Medicine twice a week. We saw evidence that junior medical staff had attended a local transferring the critically ill patient course.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit and at the bedside during our inspection.
- The six records we reviewed had evidence of a consultant admission review and treatment plan.
- There was a lead physiotherapist for ITU who visited the unit twice a day. Nurses told us they had access to occupational therapy and speech and language therapy when required. A dietician and pharmacist visited the unit daily
- The critical care outreach team visited the unit every morning and were made aware of the planned

discharges. Information provided by the trust showed that the critical care outreach team followed up between 91% and 100% of patients discharged from critical care from April 2014 to March 2015.
- The wards had a critical care outreach link nurse network; outreach staff would visit wards and provide support prior to a more complex patient discharge, for example, a patient with a tracheostomy.

Seven-day services

- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Physiotherapy was provided Monday to Friday and an on call service was available out of hours and the weekend.Consultants completed a ward round once a day at the weekend which was not in line with the twice a day recommendation from the Core Standards for Intensive Care (2013). The management team had submitted a strategy to the trust board requesting support with recruitment to enable the service to deliver this.

Access to information

- Relevant policies and guidelines were available electronically on the critical care hub and a paper copy was kept in a folder at the bedside. Not all the guidelines in the folder had review dates or versions listed, this meant staff may not be using the current guideline when delivering patient care.
- Staff were able to access blood results and x-rays via electronic results services.
- Medical staff completed a paper discharge summary. There was a plan to convert this to an electronic record that would be shared with the GP. A timescale was not available for this at the time of our inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to demonstrated some understanding of consent, the mental capacity act and deprivation of liberty safeguards.
- Mental capacity act and level one deprivation of liberty safeguards training were part of the trust's mandatory training programme. The trust provided information on training participation at directorate rather than ward level. Eighty nine percent of nursing staff and 72% of medical staff had completed mental capacity act training. Eighty nine percent of nursing staff and 70% of medical staff had completed level one deprivation of liberty training in the surgery and critical care directorate. This was below the trust's compliance target of 95%.
- Guidance for staff on the documentation of decision making around the mental capacity act was on display at the central nurses' station.
- We reviewed the folder where deprivation of liberty safeguards applications were stored. These had been completed fully for appropriate patients.
- During a ward round staff assessed a patient's capacity and the patient was involved in decision making around their care.
- Staff showed limited understanding and application of the trust's restraint policy. Staff told us they would document in the patient records and complete an incident form when mittens were applied to a patient for their safety. The restraint policy also stated a capacity assessment and risk assessment should be completed prior to the use of any restraint. Staff did not indicate any awareness of this.
- Staff told us baby monitors were used in the side rooms in case the patient could not use the call bell but could hold their hand up or make some noise. Staff told us the monitor was turned off or covered during personal care to maintain patients' privacy and dignity. There was no information displayed to patients or relatives to inform them that a monitor was in use and there was no evidence of staff obtaining consent from patients or relatives to this in the two records we reviewed. Staff showed limited understanding of the need to obtain consent for the use of the monitor.
- We informed the matron regarding our concerns with the baby monitor and limited understanding of consent and they said they would address this immediately. The trust planned to complete a Privacy Impact Assessment and related actions by 31 October 2015.
- On our unannounced visit on 6 November 2015 one patient was being cared for in the one of the side rooms where the baby monitors were in place. A draft Privacy Impact Assessment for the use of the monitors had been developed and was due to be ratified at the trust governance and assurance committee on 16 November 2015. Information for patients and relatives was displayed in the side rooms. There was no record of consent to the monitor being used in the record we reviewed.

Critical care

Are critical care services caring?

Good

We rated the service as 'good' for caring because:

- Patients were supported, treated with dignity and respect, and were involved in their care. Feedback from patients and those close to them was positive about the way staff treated people.
- We observed all staff responded to patients' requests in a timely and respectful manner. A patient told us the care they received was good.
- All staff communicated in a kind and compassionate manner with both conscious and unconscious patients.
- The multidisciplinary team involved relatives and patients in discussions about their care.
- Nurses and relatives completed a diary for patients during their stay on ITU.

Compassionate care

- We were told that the unit did not participate in the NHS Friends and Family Test because patients were infrequently discharged directly home.
- The unit did not carry out patient surveys. A comments box was available on the unit and thank you cards from patients and relatives were on display.
- One of the patients we spoke to told us they felt their privacy and dignity was maintained with the use of the curtains and the care they received from the staff was good.
- We observed all members of staff responded to patients' requests in a timely and respectful manner.
- All staff communicated with both conscious and unconscious patients in a kind and compassionate way.

Understanding and involvement of patients and those close to them

- All the patients and relatives we spoke to told us they had been kept informed of their treatment and progress and that they were involved in the decisions made by the medical team.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- One visitor told us they were able to telephone the unit any time and they were made to feel welcome.
- Staff told us that discussions around limitation of treatment took place among the multidisciplinary team. The doctors included the family in the discussion and the patient if it was appropriate.
- Nurses started a diary for patients in consultation with their relatives. Staff and relatives made entries in the diary during the patient's stay on the unit.
- Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff told us they received a good level of support from the organ donation specialist nurses.

Emotional support

- One member of staff followed a patient through the organ donation process and attended the funeral. They wanted to understand the process to enable them to support families in the future.
- Staff told us of the frustration delayed discharges caused them because of the psychological effect it had on patients. There were no patient toilet or washing facilities on the unit and there was limited space for patients to walk around.
- Staff were able to describe the process of referral to mental health and psychological support services, however, the teams rarely came to the unit and usually saw the patients once they had been discharged.

Are critical care services responsive?

Requires improvement

We rated the service as 'requires improvement' for responsive because:

- The bed occupancy was higher than the national average.
- The number of delayed discharges from ITU was higher than the critical care network average. Between 38% and 65% of discharges from the unit were delayed for greater than four hours. Seventy one percent of the causes of delay was a shortage of ward beds.
- Staff reported 10 incidents of mixed sex accommodation occurrences due to delayed discharges between March and October 2015.

Critical care

- Forty two elective operations were cancelled due to a lack of critical care bed and 46 patients were ventilated outside the unit during 15 months.
- There were eight non-clinical transfers in the six months prior to our inspection. This was not in line with recommendations from Core Standards for Intensive Care (2013).

However,

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

Service planning and delivery to meet the needs of local people

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

Meeting people's individual needs

- Staff told us they felt able to support patients with dementia and learning disabilities due to the nurse to patient ratio in critical care. The staff we spoke to were unaware of a specialist nurse for dementia or learning disabilities in the trust and said they would seek support from the nurse in charge on the unit if they needed.
- One patient we spoke to had a permanent tracheostomy and was unable to vocalise. They had been assessed by speech and language therapy who provided a letter board to allow them to communicate with staff and their visitors. The speech and language therapist had referred the patient for assistive technology to further aid communication.

Access and flow

- Information submitted by the trust showed bed occupancy in the service was consistently above the national average. It ranged between 83% and 98% from April to September 2015.
- All staff we spoke to told us delayed discharges were a frustration on the unit. The audit clerk produced a monthly delayed and out of hours discharges report. This was presented at the critical care provision group and displayed on the unit. Between 38% and 65% of discharges from the unit were delayed for greater than four hours from December 2014 to July 2015. The average length of time patients were delayed was between 15 and 38 hours. As part of the report the audit clerk analysed the reasons for the delay, 71% of the causes of delay was a shortage of ward beds. The management team acknowledged that patient flow pathways in the trust needed to improve.
- Ten patients were discharged out of hours between December 2014 and July 2015 which does not meet recommendations from Core Standards for Intensive Care (2013).
- Eight patients were transferred to another ITU for a non-clinical reason between April and September 2015. This is not in line with national guidance.
- Forty two elective operations were cancelled between April 2014 to July 2015 because of a lack of critical care bed.
- Forty six patients were ventilated outside of the unit in recovery between April 2014 and April 2015. This was due to the lack of level three beds on the unit and was part of the continuity plan. The critical care outreach team provided support to these patients between 07:30 and 20:00. Out of hours support would be provided by staff from ITU.
- Staff reported 10 incidents of mixed sex accommodation occurrences due to delayed discharges between March and October 2015. These incidents were reported internally to the trust mixed sex accommodation lead. Information submitted by the trust prior to our inspection reported no mixed sex accommodation breaches. The unit worked within the trust's privacy and dignity policy which stated that staff should "aim to ensure that patients never share a bay with patients of the opposite sex unless whilst waiting to be moved or whilst being cared for in critical care." This was not in line with Department of Health Guidance (November

2010) where it stated mixed sex accommodation was "not acceptable when a patient no longer needs level two or three care, but cannot be placed in an appropriate ward".

Learning from complaints and concerns

- The trust quality dashboard in June 2015 showed there was one PALS enquiry. The ward manager explained the issues raised in the enquiry and the change to a process that had been implemented following this. Staff on the unit were able to tell us the new process they would follow and the reasons for the changes.
- The unit displayed information on how to make a complaint.

Are critical care services well-led?

Requires improvement

We rated the service as 'requires improvement' for well-led because:

- The service did not act on issues they identified on their risk register. These delays affected staff and patient safety. Minutes of their governance meetings did not show that they effectively reviewed the risk register or developed actions. The risk register did not list out of hours medical staffing as a risk. There was no formal plan to mitigate risks to patients caused by a potential delay in their care.
- The critical care strategy had been developed in line with the trust's Healthy Lives Healthy Futures. A large financial commitment was required to meet the strategy.
- Morale varied across staff groups with themes being around changes to clinical leadership and working patterns

However,

- Recent changes had been made to the clinical leadership and time was needed to engage all staff in the changes and embed the new structure of leadership.

Vision and strategy for this service

- The management team recognised there were gaps and deficiencies in the critical care service and had developed a critical care strategy. The strategy reflected the short-term requirements in response to our 2014 inspection and also the long-term requirements of the trust.
- The vision for the unit was a co-located high dependency unit with appropriate staffing and equipment. The management team acknowledged that not all staff were fully engaged with the vision at present.
- The management team understood a large financial commitment was required to meet the strategy. This had been developed in line with the trust's Healthy Lives Healthy Futures commitment to continue to provide acute care at both the Scunthorpe and Grimsby hospital sites.
- Staff we spoke to understood the vision and strategy to be working towards a service in line with national guidelines and standards and an expansion of the service to include a high dependency unit.

Governance, risk management and quality measurement

- The management team explained the governance structure and assurance process within critical care. The monthly senior management, governance and critical care provision group meetings all fed into the trust governance meeting.
- The directorate held quality and safety days bimonthly that had multidisciplinary attendance.
- We reviewed minutes from these meetings and saw there was evidence of sharing of learning from incidents and complaints, reviews of audits and action plans; however, there was limited evidence of review of the risk register and any mitigating actions.
- We reviewed the risk register and found there had been significant delays in taking actions on issues that have been affecting patient and staff safety within ITU. Ageing and failing beds had been on the risk register since 2009, ventilators that required more frequent repairs and would not be supported by the manufacturer in 2017 had been on the risk register since 2010 and failing mattresses had been on the risk register since 2013. In all cases there were limited controls in place and therewas no evidence that any action had been taken. Funding was not available for replacement in 2015/16 capital program.
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- The management team were not aware of the problems experienced by nursing staff in relation to the failing beds and mattresses, we reviewed the incident report submitted by the trust, and four incidents had been reported between January and August 2015. The management team acknowledged that the focus had been on the strategy and planned to review the risk register as a matter of urgency.
- Staff on the unit were aware of the current risks and how to escalate these. Senior staff added risks to the risk register.
- Medical staffing, particularly overnight and out of hours medical cover was not on the risk register. Informal arrangements were in place for consultants to be requested to come in if required, however, the management team were unable to give evidence of any formal plans to mitigate against the risk to a potential delay in patient care. Long term plans were to consider the role of critical care practitioners and splitting the anaesthetic and intensivist rotas, these both involve financial support, recruitment and training.

Leadership of service

- The associate medical director and clinical lead were aware of most of the challenges ahead and could identify key actions that were required to improve the service.
- Some progress had been made since our inspection in 2014 to cross site working and standardisation of care across both sites. We saw evidence of both units using some of the same guidelines and documentation.
- Recent changes had been made to the clinical leadership of the unit and the management team were aware it would take time to engage all staff in the changes and embed the new structure of leadership.
- Junior medical staff told us they felt like a valued team members and that the consultant body were approachable and supportive.
- Nursing staff told us they felt supported by the ward manager and deputy ward manager. Senior nursing staff had training in undertaking appraisals, root cause analysis, investigations and complaints.

Culture within the service

- Staff we spoke with felt supported, able to raise concerns and that the culture on the unit was open and honest.
- Morale varied across staff groups with themes being around changes to clinical leadership and working patterns, delayed discharges and being moved off the unit to cover gaps in staffing on the wards.
- Staff sickness was between 1-3%, lower than the England average.

Public engagement

- The unit did not complete a formal patient or relative survey, the critical care outreach team fed back any comments from the follow up clinic. The ward manager did not keep a formal log of this feedback; it was shared with staff through meetings, the communication book and notice board in the staffroom.
- A “you said, we did” board was on display. Examples of changes that had been made following this feedback were changes to visiting times and introducing quiet closing bins.

Staff engagement

- The unit held regular staff meetings; we saw evidence of sharing of information from incidents, complaints and communication of relevant trust information in the meeting minutes.
- Information was also shared with staff through a secure social media page, a communication book and notice board in the staff room. Urgent issues were communicated verbally by the ward manager and nurse in charge at handover.

Innovation, improvement and sustainability

- The service was actively involved in the regional critical care network.
- Following our inspection in 2014 a medical discharge summary was now completed to ensure appropriate clinical information was shared between specialities. A check list for the ward round had been developed; we did not see this used consistently during this inspection.
- Pharmacy had introduced a new ITU specific prescription sheet across site.
- The trust had developed a deteriorating patient team. This comprised of a nurse consultant, a sepsis nurse specialist, a vascular access nurse specialist and the outreach team. Recruitment was complete but not all members of the team were yet in post.

Critical care

- The matrons in the trust met weekly to discuss the trust nursing workforce, this included incentives and awards for staff and there was a clear focus on succession planning in the service.

Maternity and gynaecology

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

Information about the service

North Lincolnshire and Goole Hospital NHS Foundation Trust provides women's services over three sites: There were Obstetric led units at Scunthorpe General Hospital (SGH) and Diana, Princess of Wales Hospital (DPoWH) Grimsby and a midwife led unit at Goole District Hospital (GDH). Community midwifery services supported all these locations.

The maternity service at SGH provided antenatal, intra partum and postnatal care. Inpatient maternity care was provided on a mixed ante /post-natal ward (26 beds), a delivery suite which had a birthing pool, and a dedicated obstetric theatre. The service was available 24 hours a day, seven days a week.

Care was provided in the pregnancy assessment centre, offering antenatal services; which opened Monday to Friday, 8am to 8pm, Saturday and bank holidays 8am to 4pm. Women with complicated, high-risk pregnancies such as women with diabetes or hypertension were seen in the centre. Services offered including vaginal birth after caesarean and pre-operative caesarean section clinics. A range of clinics including smoking cessation, and teenage pregnancy were also held at the clinic.

Women with low-risk pregnancies were looked after in the community by midwives and only referred to the centre if necessary.

Gynaecology services were also available and included Termination of Pregnancy (ToP) (12 beds).

Between October 2014 and September 2015, the total number of births at SGH maternity unit was 1911 births.

The inspection took place on the 13-16 October and 6 November 2015. The inspection team included CQC inspectors, two midwives, specialist advisors, a consultant obstetrician and an expert by experience (experts by experience are people who have experience of using care services).

We inspected the maternity and gynaecology services, including Termination of Pregnancy (ToP) service, ante/ postnatal ward, delivery suite, and obstetric theatre. We spoke with 13 women who used the service and five people accompanying them; 41 staff, including midwives, doctors, consultants, anaesthetists and senior managers. We also held a staff focus group meeting to hear their views of the service they provided. We observed care and treatment, inspected 12 sets of care records and we reviewed the trust's audits and performance data.

Maternity and gynaecology

Summary of findings

Overall, maternity and gynaecology services were rated as' good'. We rated the service' good' for safe, effective, caring, responsive and well-led. This was because:

- 'Staff were encouraged to report incidents and the majority told us they had received feedback from incidents in newsletters, emails, in team meetings and one to one meetings with their manager when they had been involved.
- There had been several changes in management and the three hospital sites were now working more collaboratively, attended joint meetings and shared good practice.
- The birth to midwife ratio was 1:25 and this was better than the national average of 1: 28.
- Women received one to one care during labour and their pain relief of choice was available.
- Women received care according to professional best practice clinical guidelines.
- In September 2015, positive feedback was received from the results of the NHS Friends and Family Test (FFT). Between 91% - 100% would recommend the services.
- At the Royal College of Midwives award in 2014, the midwifery team was recognised twice for promoting a 'normal birth experience' and were finalists in the 'supervisor of midwives team' category.

However, we also found:

- Some policies were out of date; this had been identified by the provider and steps had been taken to address the situation.
- The checks of emergency equipment were not being done consistently across all areas. This meant the equipment may not have been available in an emergency.
- The Kirkup Report, Gap analysis of the service had identified the need for a Clinical Risk Midwife and a Practice Development Midwife. However, although the management team were working on this, neither had been appointed.

Are maternity and gynaecology services safe?

Good

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

- Staff had received safeguarding training and procedures were in place to protect people from abuse.
- There was a good standard of record keeping and records were kept safe in line with data protection rules.
- The birth to midwife ratio was 1:25 and this was better than the national average of 1: 28.
- Women received one to one care during labour and escalation procedures were in place to ensure there were sufficient staff.
- Staff were encouraged to report incidents. They received feedback in newsletters, emails, in team meetings and one to one meetings with their manager when they had been involved.

However, we also found:

- In one area, several staff reported they had not received feedback from incidents and when spoken with further, they told us they had not always read their emails, viewed newsletters or attended meetings.
- We found the checks of emergency equipment were not being done consistently across all areas to ensure it was available in an emergency.

Incidents

- We found there was a 'Maternity Services Trigger list which staff followed for incident and near miss reporting. Examples of these included: missed child protection issues, readmission of a baby to the service, caesarean section, and compromised staffing levels. This list also provided a guide to staff as to those incidents that required escalation as serious incidents and these included all unexplained or unexpected uterine deaths over 24 weeks, maternal deaths and birth injuries.
- Midwives and staff told us they were encouraged to report incidents and were able to explain the procedure. Between August 2014 and July 2015, there had been five serious incidents reported across the trust in women's services. One examples of these were, due to poor record keeping some routine appointments for Downs

Syndrome screening had been missed. A second example was, there had been a Core Network switch fault which had resulted in an information technology crash of the network services. Information showed there were business continuity guidelines in place of the action to take, should a similar incident occur.

- Supervisory investigations into two of the incidents was carried out; a root cause analysis (RCA) had taken place into the remaining three incidents. A RCA is a method of problem solving that tries to identify the root cause of incident. When incidents do happen, it is important lessons are learned to prevent the same incident occurring again. An action plan and recommendations summary had been shared with all staff.
- Prior to inspection the trust provided a 'Maternity Incidents Overview Report' (8 October 2015). Within the report it identified the actions that had been taken to address incidents. It stated all incidents were sent to the management team. This included the Operational Matron, Head of Midwifery (HoM) and Risk & Governance Facilitator. It stated, escalation of any potential serious incidents were verbalised to the management team and acted upon in a timely way. An RCA was also done for incidents which were not classified as serious.
- Information provided by the trust told us 'all incidents, complaints, PALs concerns and claims were analysed and reported on a monthly basis to the Women's and Children's Directorate, Governance Meetings for their oversight and action where necessary.
- Forums where incidents were discussed included, a monthly clinical governance meeting; clinical review meeting; perinatal meeting, and the trust governance and assurance committee. Departmental meetings included, monthly team leader meetings, operational meetings, supervisor of midwives meetings, and strategy and delivery meetings.
- The clinical review committee met monthly and the minutes of the meeting, dated 10 April 2015, showed the staff who attended included, the lead Supervisor of Midwives (SoM), the HoM, obstetrics and gynaecology consultants, midwives, consultant anaesthetists, and other medical staff. Agenda items discussed included, a review of clinical incidents, and actions and leaning taken place.
- Perinatal mortality and morbidity meetings took place monthly. Cases were discussed and included, themes, recommendations, actions and learning, where appropriate.
- We found when we inspected the service, there were eight incidents which had not been investigated since June 2015.The HoM and the Obstetric Clinical lead confirmed following the inspection, the incidents had been investigated and no longer remained outstanding.
- There was an area on the incident form where staff could request individual feedback once the investigation had been completed; staff confirmed this had been the case. Staff across the service reported they had received feedback from incidents in newsletters, emails, in team meetings and one to one meetings with their manager when they had been involved. The feedback was to disseminate learning from incidents or other concerns which had occurred within the trust. However, several staff reported they had not received feedback and when spoken with further, they told us they had not always read their emails, viewed newsletters or attended meetings.
- We saw changes as a result of learning from incidents. For example, due to poor record keeping staff had not recorded a woman's wishes in relation to them having screening for Downs Syndrome and the screening had been missed. As a result, all midwives routinely discussed Downs screening at 14-16 week of pregnancy to eliminate missed screening and documented discussion outcomes. Staff from this department were able to tell us about the incident and the action taken following lessons learned. We were also informed the policy for antenatal screening was updated to reflect the change in practice.

Duty of Candour

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

Cleanliness, infection control and hygiene

- Staff reported they had infection control training. Information provided by the trust, showed infection control training across women's services, was 85% and some staff that had recently started working there, had yet to receive their training.
- We saw the trust had an infection control policy and staff knew where to locate a copy.
- Trust policies were adhered to in relation to infection control; such as the use of hand gel and 'bare below the elbow' dress code.
- Hand wash audits we reviewed showed 100% compliance.
- The maternity unit and gynaecology ward were visibly clean. Cleaning records on the ante/postnatal ward, showed evidence cleaning had taken place and satisfactory records were kept for the months of April to October 2015, when privacy curtains had been changed.

Environment and equipment

- Access to the delivery suite and wards was via an intercom system and staff were able to monitor people visiting and leaving these areas.
- A wrist band, tagging system was used for the security of babies in the hospital. This meant no one could leave the ward or unit with a baby without sounding an alarm. However, we did witness a faulty alarm and staff on the ward told us the system frequently alarmed. At the time of the visit staff were seen and heard checking with delivery suite when an alarm sounded. The staff told us, when the wrist band was first fitted to the baby and put onto the system, it sometimes alarmed. We also witnessed a baby alarm sounding in one of the rooms; staff were seen checking the security of the baby and room.
- To promote choice during labour, 'The Butterfly' room, was used to promoted natural labour and available to women assessed to be at low risk of complications. The room had no monitors and equipped to help promote a natural birth. A grant from the Department of Health had been awarded to the maternity services and this had helped to fund equipment for this room.
- We saw equipment was available to meet people's needs. For example, piped oxygen and cardiotocograph (CTG) machines.
- The trust provided records of the delivery suite, daily, infant resuscitaire, equipment checks. The documentation showe, there had been several gaps in recordings, for the equipment in room's two to six. For example room three, between 5-7 October 2015, there were no record to show the equipment had been checked. On ward 26, in August 2015, there were 11 days when the adult resuscitation trolley equipment, had not been checked. This meant, the emergency equipment may not be available for use in an emergency.

Medicines

- We were told the hospital pharmacist was responsible for routine checking and monitoring of medicines. Medicines were stored correctly, which included emergency medicines and we found appropriate checks had been carried out. We also saw prescription charts had been completed correctly, dated and signed.
- When we visited the labour ward on the 13-16 October 2015, we found the room where the intravenous fluids were kept was not locked. At the inspection on 6 November 2015, we found the door was locked. A lock had been fitted and staff were seen to be experiencing difficulty, when using the newly fitted, locking device.
- A random sample of refrigerator, temperature recordings were inspected. On the gynaecology ward, we saw daily recordings had taken place between September and October 2015 and satisfactory records had been maintained.

Records

- We inspected twelve sets of care records and found they were of a good standard of record keeping. The records included: a situation, background, assessment, recommendation (SBAR) transfer record, which had been used when handing over care between staff. The tool was used in maternity services, where there may be multiple handovers between staff, and it had assisted in improving communication.
- Venous thromboembolism (VTE) risk assessments had been completed in all of the records inspected during the ante natal, labour and post-natal period. Clear, birth plan pathways, risk assessment tools, and growth charts, had also been completed.
- The service used the Modified Early Obstetric Warning Score (MEOWS). This assessment tool enabled staff to identify and respond to the need for additional medical support if required. The MEOWS identified directions for escalation, and staff were aware of the appropriate action to take if patients scored higher than expected. We looked at completed charts; the documentation had been completed appropriately.

- Arrangements were in place to ensure checks were made before, during and after surgical procedures in accordance with best-practice principles. This included completing the 'five steps to safer surgery, ' World Health Organization (WHO), surgical safety checklist. The documentation we inspected had been completed correctly.
- Consent had been recorded; following theatre, there were detailed recovery observations, fluid balance charts; obesity care pathway, where appropriate; CTG check stickers; evidence of good MDT working; medical involvement, care planning and daily reviews by medical staff.
- A 'Fresh eyes approach' (Fitzpatrick and Holt, 2008) was used when monitoring fetal wellbeing through the use of cardiotocography (CTG), to improve patient's safety. The 'fresh eyes could enhance the accuracy of CTG interpretation as the tracings were viewed by more than one person.
- Staff told us as part of their annual supervision with their supervisor, they had three sets of records audited and discussed as part of their learning.
- In March 2014, the directorate achieved compliance against Level 2, National Risk Management Standards, and achieved 10/10 for the quality of record keeping.
- A medical records audit commenced across the trust in April 2015. Results showed the records were dated and legible, however they were not always signed. The trust also provided a document which showed a further, record keeping audit across the trust had been taking place and due for completion in November 2015. The objective of the audit was to monitor compliance with basic standards for record keeping, involve midwifery staff in auditing their own practice and provide evidence to support the trusts, National Health Service, Litigation Authority accreditation.

Safeguarding

- Data provided by the trust showed 89% of staff had received adult safeguarding training, and 80% of staff had received level three children's safeguarding training. This was not compliant with the trust'strust's own target. We were told by senior managers, this was because new medical staff had joined the service in August 2015, and they were yet to complete their mandatory training.
- There was a trust wide safeguarding lead for adults and children and a named midwife for safeguarding.
- We found there were procedures in place for protecting adults and children from abuse; Staff were able to explain the procedure for reporting allegations or suspected incidents of abuse, including adults and children.
- We saw documentation and a screening tool used in the antenatal period, for identifying domestic abuse.
- Staff were aware of safeguarding procedures which included: The early identification and reporting of Female Genital Mutilation (FGM); the response in the event of a suspected or actual child abduction (policy– Review date April 2018).
- Women received a leaflet at booking about 'Having a Safer Pregnancy' and this included information about the trusts zero tolerance to violent, threatening and abusive behaviour.

Mandatory training

- Staff confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training. Staff said they had attended annual multidisciplinary, skills and drills training, and obstetric emergency study days.
- Information from the trust dated October 2015, showed staff had annual obstetric skills and drills training in areas such as cord prolapse, post-partum haemorrhage and 83% of staff had completed their three yearly mental capacity act training.

Assessing and responding to patient risk

- There were guidelines and risk assessment relating to labour and/or delivery in water and staff were able to give examples.
- The unit used the Modified Obstetric Early Warning Scoring (MOEWS) and staff were aware of the appropriate action to be taken if women scored higher than expected.
- Arrangements were in place to ensure checks were made before, during and after surgical procedures in accordance with best-practice principles. This included completing the 'five steps to safer surgery,' World Health Organization (WHO), surgical safety checklist. The documentation we inspected had been completed correctly.

Midwifery staffing

- Data provided at the inspection showed the birth to midwife ratio was 1:25 and this was better than the national average of 1: 28.
- Women we spoke with told us they had a named midwife responsible for their care and received one to one care during labour. This information was confirmed by staff during our inspection. We did not see any trusttrust data, that had been collected to monitor and confirm this.
- We were told by staff on the delivery suite that previously sickness had been problematic, but this was not an issue at the moment.
- Safe staffing levels were monitored and managed on a daily basis by each ward/unit manager, and the overall responsibility was with the delivery suite co-ordinator. The duty rota was in paper and electronic format.(E-rostering)
- We saw a comprehensive daily staffing situation report and it included the dependency of patients/women using the service; this was supported by an escalation process to manage staffing levels. (Dated 23 June 2015) Following the inspection we were also provided with a copy of their revised policy for safe staffing levels; expiry date 2018.
- We saw a handover taking place from day to night staff on the labour ward. Clear information was provided and included: staffing levels of the unit, the number and dependency levels of women, and compassion and support.
- Ward staff reported the co-ordinators telephoned and visited the ward for updates and they felt supported by the process.
- Staff reported that at busy times in labour ward, they had been moved from the ante/ postnatal ward. Although the dependency levels were monitored, they sometimes felt to move staff could have had an impact on the ward. The labour ward co-ordinator told us in the first instance they would take staff from the ward, but if the ward was busy they would ask the community midwives to assist with the cover.
- We found each area had planned and actual staffing levels visible for staff and people to see. On the week of the inspection and the visit on 6 November 2015, the staffing levels were the same as those planned.
- Staff reported the shifts were 12 hours and they were entitled to a one hour break. However, due to the nature of the role and the requirements of the ward, this was not always possible. As a result staff told us they logged their time owing and would receive it back at a more convenient time. This was said to be monitored by the ward manager and an incident form completed when staff were moved to delivery suite.
- We found on our visit of the 6 November 2015, a midwife had been recruited for a 9-5pm shift to cover the admissions of the elective caesarean sections to the ward.
- We were told the leadership team manually managed the e-rostering as it did not take into account skill mix.
- The labour ward co-ordinator told us there had been a recruitment of several ward managers and they would be in place by the 1 December 2015. This included a labour ward manager and a perinatal assessment unit manager. This meant there would be more support for staff in providing these services. In addition to the midwives, there was a ward clerk and a health care assistant. The labour ward co-ordinators were supernumerary in line with good practice guidance; however we were told some would allocate themselves a patient.
- There was no clinical risk midwife, or practice development midwife in post at the time of the inspection. A trust gap analysis of the Kirkup Report had identified the need for these posts. We were told by management that they were preparing business cases to address these gaps.

Medical staffing

- Information provided by the trust showed consultant anaesthetist, labour ward cover, was ten hours a day on site, Monday to Friday (50 hrs a week). There were 16 anaesthetist consultants and this equated to a 1:16 on call. On call was 6pm to 8am Monday to Friday, and Saturday and Sunday 8am to 8am.
- There were six consultant obstetricians with an on call arrangement of 1:6. Figures showed a consultant was on site between the hours of 9 am to 7pm Monday to Friday, and Saturday 9am to 2pm. Consultant on call cover was then provided Monday to Friday 7pm to 9am, and at the weekend 1pm to 9am (with an overlap of 1 hour between 1 – 2pm). This was in line with the Royal College of Obstetricians & Gynaecologists (RCOG) best practice standard for consultant labour ward cover.
- The CQC data pack showed there were 42 WTE medical staff; 25% of consultants compared to the England

average of 35%. Middle grade staff levels were 21%, compared with an 8% England average, and there were 39% registrars and 14% junior doctors. These compared with the England average of 50% and 7% respectively.
- Medical staff were available when needed and staff reported antenatal patients were seen each day, and this was in line with current guidance. Patients told us they received consultant and medical care, which met their needs.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Good

We rated the service as 'good' for effective because:

- Women received care according to professional best practice clinical guidelines.
- Pain relief of choice was available for women in labour. Information about outcomes for women were routinely monitored and action taken to make improvements.
- Staff had the skills, knowledge and experience to do their job.

However we also found:

- Two gynaecology patients had been admitted to the antenatal ward and were being nursed by midwives who did not have the relevant nursing qualification, skills and experience. It was brought to the attention of the provider who had acted promptly to address the situation and removed the patients from the ward.
- Some policies were out of date; this had been identified by the provider and steps had been taken to address the situation.

Evidence-based care and treatment

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

Pain relief

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

Nutrition and hydration

- Women were given advice on healthy lifestyle choices and nutrition during pregnancy; we saw information relating to this in the antenatal clinic and available in each area we visited.
- The service had two Infant feeding leads, one with a parent education element to the role (1.00 WTE).
- The service had achieved level 2 UNICEF Baby Friendly in July 2015. The UNICEF Baby Friendly initiative is a worldwide programme that encourages maternity hospitals to support women to breastfeed.

- The trust dashboard figures showed the breastfeeding initiation rates had been combined for Goole Midwife led unit with those of Scunthorpe General Hospital (SGH) and ranged between 58.7% in October 2014 to 74.6% in August 2015, the trust target was 74.4%.

Patient outcomes

- The CQC 'Intelligence Monitoring Report' – May 2015, did not identify any maternity outliers in the following areas: maternal readmissions, emergency or elective caesarean sections, neonatal readmissions, puerperal sepsis and other puerperal infections.
- Between October 2014 and September 2015, the total number of births was 1911; this included 12 deliveries where the birthing pool was used.
- The maternity dashboard information provided by the trust gave combined figures for SGH and Goole District Hospital. It showed: the normal delivery rate was 73.1%, compared to the national average of 60.1%. The elective lower segment caesarean (LSCS) was 7.6%, against the national average of 10.9% and the emergency LSCS rate was 11.3%, which was lower than the national average of 15.1%. This showed the service achieved better outcomes for women in comparison with the national average.
- Data also indicated that between October 2014 and September 2015, the third degree tear rate following a normal birth was 2.5%.
- The percentage of patients having a blood loss following birth of more than 1500ml was 1%, which was also a combined percentage for both hospital sites.
- Both Scunthorpe General and Diana, Princess of Wales hospitals, met one of the five NNAP (National neonatal audit programme) standards in 2013. At Scunthorpe they met the standard of 98-100% of babies having their temperatures taken within an hour of birth.

Competent staff

- Midwives had statutory supervision of their practice, and staff confirmed they had access to a supervisor of midwives for advice and support 24 hours a day.
- Information provided by the trust showed out of 223 midwives, 98% had completed their annual supervisory review.
- Information also provided by the trust showed several midwives were trained in new born and infant physical examination (NIPE). This helped with flow in the service and a better outcome for women and their families.
- We spoke with newly qualified staff and were told the hospital was a good place to work and it was a safe place to have a baby. They said they had a named Supervisor of Midwives (SoM), preceptorship for eighteen months and worked two weeks supernumerary.
- Figures showed the supervisor to midwife ratio was 1:15 and this was in line with the national guidance of 1:15.
- Information provided dated 9 October 2015, showed 100% of consultants were up to date with their appraisals and 86% of middle grade doctors.
- We found two gynaecology patients had been admitted to the antenatal ward and were being nursed by midwives. The midwives did not all have the relevant qualifications, skills and experience to care for these patients. The midwives potentially compromised their professional registration by doing this. We were told this happened approximately twice per month. It was brought to the attention of the provider who told us they had acted immediate to address the situation.

Multidisciplinary working

- Staff reported good communication and information sharing between departments and cross site working within the team. For example in delivery suite, staff told us how their recent cross site working in the delivery suite at the Diana, Princess of Wales Hospital (DPOW) hospital, had helped them share and reflect on good practice as a team. Information from the trust in the 'Maternity Incident Overview Report' showed as changes following efforts to 'learn lessons' Grimsby and Scunthorpe co-ordinators would rotate to ensure sharing and learning from different ways of working and good practice promoting a trust approach to service provision.
- Staff reported they had good relationships with the medical staff in the care of patients and they worked well as a team.
- There were clear processes for multidisciplinary working in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers post-natally 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.
- Staff worked closely with children's services to care for babies admitted to the transitional care unit.

- Communication was sent to GP via email on discharge from the service. This detailed the reason for admission and any investigation results and treatment undertaken.
- Clinicians worked closely with GPs and social services when dealing with safeguarding concerns, such as child protection.

Seven-day services

- Consultant's obstetricians were available on site each day and were available outside of these times via on call arrangements. Anaesthetists were on site 24 hours a day.
- We found there was access to pharmacy and out of hours services were provide.
- The antenatal services were available 8am to 8pm Monday to Friday, 8am to 4pm Saturday and bank holidays. This offered choice to women and those who were not able to attend during the day 'normal' working day.

Access to information

- A 'Hand held book' was used for recording women's antenatal, intra partum and postnatal care. This was kept by women and completed as part of a record of their care between GP's, midwives and obstetricians where appropriate.
- Staff reported no problems in obtaining diagnostic results
- An IT system was used to monitor and track patients, which was displayed at the nurse's desk.

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

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

Are maternity and gynaecology services caring?

Good

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

- The unit provided individualised care to people using the service and they were treated with privacy, dignity and respect.
- In September 2015, positive feedback was received from the NHS Friends and Family Test. Between 91% - 100% would recommend the services.
- The trust had midwives with a lead role in bereavement. They provided support, compassion and care for women and their families in time of bereavement.

Compassionate care

- In September 2015 the NHS Friends and Family Test results showed: 93% of women who used the service would recommend the antenatal service to friends and family if they needed similar care or treatment; 100% of women would recommend the labour ward; 94% would recommend the postnatal ward and 91% recommend the postnatal community service to friends and family if they needed similar care or treatment.
- Results from the CQC maternity survey 2013 relating to maternity services across the trust, showed for antenatal care, labour, birth, and postnatal care they scored about the same as other trusts. There were three areas they scored better than other trusts. These included: How women were spoken with during labour and birth; were they treated with respect and dignity, and their confidence and trust in the staff during their labour and birth.
- When in labour, women were encouraged to bring their birthing partners with them and made to feel welcome.
- Twelve out of the 13 women we spoke with commented positively about the treatment and standard of care they had received. They had continuity of care from their midwife, received 1:1 care during labour and were treated with dignity and respect. One woman told us,

that pre-natally the staff did not believe they were having contractions and they felt they had conflicting advice. They also told us their care in delivery was very good.
- We saw letters/cards of appreciation and positive comments about people's experience of the unit.

Understanding and involvement of patients and those close to them

- Women we spoke with stated they had been involved in decisions regarding their choice of birth and felt supported by staff.
- In the CQC survey completed in 2015, for being involved enough in decisions about their care during labour and birth, women scored the trust 8.5 out of 10 (which was about the same as other trusts and no change from the 2013 score).
- Two women whose babies were in the neonatal intensive care unit, told us the staff on the ward and the unit were good. They said the staff ensured they were involved and saw their babies as much as possible. One woman told us they were due to be discharged from the postnatal ward and arrangements had been made for them to use one of the hospital flats so they would be separated from their baby as little as possible.

Emotional support

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

Are maternity and gynaecology services responsive?

Good

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

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

Service planning and delivery to meet the needs of local people

- The trust was aware of the risks to the service such as staffing levels and skill mix, geography of the three trust sites and investment in community services. It worked with local commissioners of services, the local authority, other providers, GPs and patients to co-ordinate care that met the health needs of women.
- Services were planned and delivered to enable women to have the flexibility, choice and continuity of care wherever possible.
- The gynaecology ward and antenatal/postnatal wards were open for visiting 2.30 – 4pm and 6.30 – 8pm each day.
- The antenatal day unit; opened Monday to Friday, 8am to 6pm, and the antenatal clinic, open Monday to Thursday 8.30am to 5.30pm, and Friday 8.30am to 4.30pm.
- Visiting times were: Partners: 10:00am to 8:00pm, Family and Friends: 2:00pm to 4:30pm and 6:30 to 8:00pm.

Access and flow

- The service did not close between January 2014 – June 2015.
- Bed occupancy for women's services 2014/2015 was between 41.4% - 55.1%. This was lower than the England national average of 60% and in line with the Royal College of midwives recommendations.
- Between January 2015 and September 2015 92.5% -100% of women had an antenatal booking within 13 weeks of pregnancy; the threshold target was 90%.

- Women spoken with confirmed they were seen throughout their pregnancy when expected and when visiting the service, they told us they did not have to wait to be seen.
- Midwives carried out examination of the new-born for all low-risk pregnancies and post-natal examinations. This assisted in the timely discharge of women and their babies from the service.
- A dedicated bay of four transitional care beds was provided on the postnatal ward. Transitional care was an area where babies who needed a little more nursing care and monitoring could stay with their mum rather than go to the Special Care Baby Unit. This meant mum could continue to be the main carer of their baby.
- Gynaecological services were provided in 12 inpatient beds and included Termination of Pregnancy (ToP). It was a nurse led ward offering medical and surgical ToP. Should a teenager be admitted the consultant midwife for teenage pregnancy could be contacted for support and advice. We were told counselling was carried out by the nurses on the ward although they had not received any formal training.
- We saw information in the ward and departments about the hospital chaplaincy; offering spiritual, religious and pastoral care; support to staff, patients, their relatives and friends. The service could be accessed via the ward/department staff or by telephone, was available on-call out of hours, and included when a persons need was urgent.

Meeting people's individual needs

- Women carried their own paper records with them and had contact numbers for the delivery suite and midwives should they need advice or need to go into the unit.
- Information booklets and guidelines were available and these included: Role of Birth Partners, Vitamin K, and Information for Parents, Having a Safer Pregnancy, Parent education classes, health education and advice to achieve and maintain a healthier lifestyle.
- Midwives were available who had a special interest in learning disabilities, safeguarding, bereavement and teenage pregnancies. There were no specialist midwives for patients with bariatric or alcohol problems.
- Staff could access interpreter services if required for women whose first language was not English.
- There was relevant clinical information displayed in the antenatal clinic for women and their partners to read.

Learning from complaints and concerns

- The service had a system in place for handling complaints and concerns. Their complaints policy dated March 2015 was in line with recognised guidance. The trust had a designated complaints manager and a customer service department.
- We saw information on the intranet and on the notice board in the antenatal clinic advising patients and visitors of how to complain. The leaflet available in the clinic was called, 'Tell us what you think, customer services' And 'How to make a complaint suggestion or pay a compliment about our hospitals.' The role of the complaints manager and the customer service department were explained in the information and there were contact telephone numbers and addresses to assist patient in accessing these services.
- There was a 'Complaints and Concerns Training Workbook' for staff to complete and be signed by their manager to show they had completed the training. This was to give staff an awareness of the procedures to follow should someone wish to express their concerns or complain.
- Staff we spoke with were aware of the complaints policy and the procedure to follow should someone wish to complain.
- We did not see specific data relating to Scunthorpe women's services in their management of complaints. However, their complaints and performance analysis document showed complainants had the opportunity to meet with staff to discuss and receive answers to their concerns and this was then followed up in writing.
- Information was seen in the quarterly 'Trust Governance and Assurance Committee' report (dated 14 September 2015), that an analysis of complaints had taken place by the complaints manager. The information showed between August 2014 and June 2015 100% of complaints across the trust had been closed each month within their agreed timescale.
- Staff told us they were made aware of lessons learned from complaints and these were included in staff emails, newsletter, and their team meetings.

Are maternity and gynaecology services well-led?

Maternity and gynaecology

Good

We rated the service as 'good' for well-led because:

Overall, we rated the service as 'good' for well led. This was because:

- The Maternity Service Liaison Committee (MSLC) was run by a group of parent representatives who worked with the midwives, doctors, healthcare professionals and commissioners to guide and influence maternity services at the trust. The Chair told us the trust was inclusive, open and honest in their approach and they were kept informed of the changes and involved in the development of guidelines.
- At the Royal College of Midwives award in 2014, the midwifery team was recognised twice for promoting a 'normal birth experience' and was finalists in the 'supervisor of midwives team' category. The trust had an annual 'Our Stars 2015' awards ceremony for staff to reward them for innovation and good practice.
- There had been several changes in management and changes continued as DPOW, SGH and GDH were working more collaboratively, attending joint meetings and sharing good practice.
- The majority of staff told us they knew who the Chief Executive was and they communicated well. They told us their line manager was approachable, supportive; teamwork was good and they felt listened to.

However, we also found:

- The trust'sA few staff told us their moral was low and they did not always feel valued or listened to.
- Following publication of the Kirkup report, the trust's gap analysis identified the need for a Clinical Risk Midwife and a Practice Development Midwife. The management team were working to address these shortfalls.

Vision and strategy for this service

- The trusts vision for the service was, 'Every woman and child in our locality is healthy and happy;' Their mission statement was, 'To provide safe, effective and leading edge care to the population we cover through nurturing high performing teams that prioritise patient experience'; and their strategic objectives.'
- A copy of their 'Strategic Plan Document 2014-19' was seen on the internet. It stated its vision and values had been created with input of staff from all levels of the organisation; they reflected their shared values, ideals and principals and strengthened their commitment to put patients first. An example of their shared values were: 'We care about quality and patient safety. We care about positive experiences for patients, carers and staff. …..and we care about doing the right thing, each time, every time.'
- Information provided by the trust dated 8 October 2015 stated they had: "a business plan to recruit a practice development midwife post to ensure learning lessons continued from all complaints, incidents or general feedback enabling and supporting colleagues in the team through one to one working."
- They were "Working towards opening an obstetric theatre available as a dedicated suite for the service enabling 24/7 access."
- "To improve the patient experience and support following bereavement, a dedicated bereavement room is a development plan for the future, to be further supported by a bereavement midwife post focussing on this area to provide necessary care and support at this difficult time."
- "Looking into a triage service for both sites." "Improve morale and team working……"

Governance, risk management and quality measurement

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

Governance Dashboard, complaints analysis report, lessons learned and action plans, RCA incident action plans, risk register, NICE guidance and action plan, safety alerts, mandatory training updates, trust mortality morbidity updates, falls action plan to address shortfalls and lessons learnt. This showed the service monitored and responded to identified risks.

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

Leadership of service

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

Culture within the service:

- The majority of staff told us there was an open culture and they were encouraged to report incidents and risks.
- There had been several changes in management and changes continued as SGH, DPOW and Goole District Hospital were now working more collaboratively, attending joint meetings and sharing good practice.
- Staff told us their line manager was approachable, supportive; teamwork was good and they felt listened to.
- However, a few staff told us their morale was low and they did not always feel valued or listened to.

Public engagement

- We spoke with the Chair of the Northern Lincolnshire, Maternity Service Liaison Committee (MSLC). The MSLC was run by a group of parent representatives who worked with midwives, doctors, healthcare professionals and commissioners to guide and influence maternity services at North and North Lincolnshire. The Chair told us the trust were open and honest with the MSLC and part of their role included attending clinical governance meetings and development of maternity guidelines.
- As part of their role the MSLC looked at what was working and what needed to change. We were told meetings took place every two months; meeting minutes for April 2015 showed eight people attended and included patient representatives, Head of Midwifery & Gynaecology, a Supervisor of Midwives, and a Breastfeeding Support Midwife. Items discussed included: a Tongue-tie referral pathway for breastfed babies; the maternity dashboard figures and steps the service were taking to reduce the stillbirth rate, and perinatal mental health.
- We saw from the minutes a working group had met (, the midwife with lead role for public health was part of this group) to discuss perinatal mental health and were drafting recommendations to the Maternity Partnership Board. These were to be discussed at a subsequent MSLC meeting. This showed the service was proactive in working with the public and people who used the service; with a view to keeping them informed and improving the service.

- The trust also had a 'Quality and Patient Experience committee,' and a 'Patient Experience Strategy.' The committee had carried out an inpatient survey and identified three areas for improvement; these areas were not part of women's services.

Staff engagement

- Staff reported they had an annual 'Our Stars 2015' awards ceremony for staff of Northern Lincolnshire and Goole NHS Foundation Trust. The most recent one was held, on Friday 2 October 2015. The event saw nine awards given to dedicated staff and volunteers
- Monthly briefing took place to keep staff up to date with events across the trust; Staff talked about their monthly team/across site meetings where incidents, learning, training, and changes were discussed. One member of staff told us, the monthly meetings were attended by managers from each hospital site; the location was also alternated between the SGH and DPOW sites. They said there was a 'good attendance' and staff were kept informed.

Innovation, improvement and sustainability

- The service had successfully secured funding of £36,550 from the Nursing Technology Fund. A national fund which the Prime Minister establishment in 2012 to support nurses, midwives and health visitors to make better use of digital technology. These monies provided a bespoke Web V 'virtual ward' system and flat screen computers were installed in all ward. We saw these in use on the delivery suite and as they were relatively new, staff were still learning the technology in their daily use.
- Digital pens for community midwives were also purchased as part of the funding and will be used to write on specially designed patient notes; the community midwife would then place the pen in a docking device which would upload the information on a computer without the midwife having to spend time re-inputting the data into the computer. The pens had been purchased and the system was reported to go live at the beginning of November 2015.
- As part of changes headed by NHS England the service now had two new-born hearing screeners and supportive technology. This meant babies born at the hospital received a hearing screening test soon after birth. Previously babies had to wait to be seen by a health visitor once they were at home.
- At the Royal College of Midwives award in 2014, the midwifery team were recognised twice for promoting a 'normal birth experience' and were finalists in the 'Supervisor of Midwives team' category.

Outpatients and diagnostic imaging

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

Information about the service

Scunthorpe General Hospital (SGH) had outpatients (OP), phlebotomy and radiology departments. These were part of clinical support services within the trust. Pathology services, known as 'Path Links', was a directorate in its own right.

The radiology department had four general X-ray rooms and a minor specialist room, used for interventional radiology. The £3.2 million state-of-the-art Blue Sky imaging suite at SGH provided a seven-day diagnostic service for CT, MRI and non-obstetric ultrasound scans. There was a mobile unit in the accident and emergency department, which provided a 24-hour seven-day service.

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

There was a pathology laboratory 24-hour seven-day service on site, which included a phlebotomy service. The phlebotomy service held clinics five days a week and provided a service to the inpatient wards six days a week. Ward staff took blood samples on the inpatient wards on Sundays; pathology wanted to extend their phlebotomy service to seven days a week, but this depended on funding approval.

Between 1 October 2014 and 30 September 2015, the OPD at SGH saw 161,535 patients. Radiology attendance figures at the SGH site during this period was 157,450.

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

We spoke with 12 patients and three relatives in the OP clinics, including ophthalmology, and five patients in the radiology waiting area, who shared their views and experiences of the service with us. We also spoke with 44 staff including radiologists, consultants, managers in pathology, radiology and outpatients, nurses, radiographers, support workers and administrative staff.

We reviewed 10 patient care records in the ophthalmology clinic and four sets of patient care records in radiology to track patient's care.

Outpatients and diagnostic imaging

Summary of findings

We found the outpatients and diagnostic imaging core service to be rated as inadequate overall because:

- There was evidence of harm to patients within the outpatient services because of poor management of the follow up appointment system. There were no significant concerns identified within the diagnostic services we inspected; we found patients were protected from avoidable harm and received effective care.
- Between September 2014 and the time of the inspection, five serious incidents were reported in ophthalmology where patients had suffered harm due to delayed diagnosis and treatment. There was a lack of evidence to demonstrate feedback, follow up actions and learning from incidents in outpatients.
- There was a trust-wide backlog of 30,667 outpatients without follow-up appointments, the majority were in ophthalmology. At the time of the inspection the service had no clear action plan to address the immediate clinical risk to patients.
- The number of patients who did not attend outpatient clinics was above 10% and the number of cancelled clinics in outpatients and ophthalmology had increased since the last inspection. The did not attend rate was much lower in radiology at SGH between 1 October 2014 and 30 September 2015 was 2.47%. There were a high number of cancelled appointments with some appointments cancelled on the day. There was also evidence that the decisions to cancel appointments had no clinical input.
- The trust undertook a validation exercise to identify and prioritise those patients who required an appointment in ophthalmology. The trust assured us that all of the 441 outstanding ophthalmology patients would have appointment dates and their appointments completed by 31 December 2015.
- For specialities other than ophthalmology a similar system was to be implemented and again the trust assured us that all patients needing an appointment would have one booked by 31 December 2015. The latest information from the trust indicated that all patients had been validated and those requiring appointments had been given them or would be at the required time .
- Services provided by the radiology departments and trust policies were based on nationally recognised guidance such as NICE and Royal College guidelines. Staff in radiology were competent to carry out their roles, and there was evidence of multidisciplinary working.
- During our inspection, patients and relatives commented positively about the care provided from all of the outpatients and diagnostic imaging staff. Staff working in the departments treated patients politely and with respect.
- Systems were in place in radiology to ensure that the service was able to meet the individual needs of people such as those living with dementia or a learning disability, and for those whose first language was not English. However, we found services in outpatients were not planned and delivered to ensure the additional needs of these patients groups were being met.
- Systems were in place to capture concerns and complaints raised within both departments, review these and take action to improve the experience of patients. We found there were high numbers of formal and informal complaints about the administration of appointments in the OPD.
- Staff in both departments told us their line managers were supportive. Staff and line managers both told us there was an open culture and good teamwork within the departments. However, there was a lack of management oversight of the significant problems with the OP clinic booking systems.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate

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

- The high numbers of clinic cancellations and lack of robust follow up of cancelled appointments led to delays in patients receiving treatment and diagnosis. There were seven serious incidents recorded between September 2014 and the time of the inspection. Five of these were in ophthalmology and two in other outpatient specialties (one in breast services and one in respiratory). These related to delays in diagnosis and had resulted in permanent harm to patients.
- The root causes of these incidents included delayed treatment due to cancelled appointment and failure to follow up in a timely manner. There was not enough evidence to show the service gave feedback, developed follow up actions or learnt from incidents. Practice had not been changed in response to the incidents, which had been reported. The centralised Clinical Administration Support Team (CAST) appointment bookings team was significantly under establishment and did not have the training and support in place to ensure patients were booked for appointments according to clinical need.
- The facilities and premises were not appropriate for the services delivered. For example, there were very few designated waiting areas or rooms and we observed patients sat on chairs along the sides of the corridors. This made access for patients in wheelchairs, or with mobility aids difficult. Staff were not recording minimum and maximum fridge temperatures which was necessary for safety and efficacy of the medicines.
- In the fracture and orthopaedic OP clinic there were several carpeted areas, including waiting areas and clinical rooms. There were also carpets in the phlebotomy waiting room. This meant staff could not clean these areas to the required standard.
- There was sufficient clean and well-maintained equipment to ensure that patients received the treatment they needed in a safe way. Resuscitation trolleys in both OP zones were easily accessible to staff in the event of an emergency.
- Cleanliness and hygiene in other OP and diagnostic imaging departments were within acceptable standards, with high levels of compliance in infection control audits.
- Records showed the numbers of staff that had received mandatory training was just below the trust compliance target of 95%.
- There were sufficient numbers of suitably qualified non-medical staff to meet the needs of the people using OP and diagnostic imaging services.
- There were ten unfilled vacancies for medical staff in radiology but the department was managing this shortfall and had plans to recruit radiologists from abroad. We found there was no detrimental effect on the care and treatment patients received due to the shortage of medical staff in radiology.

Incidents

Outpatients

- Record submitted by the trust showed there had been 166 incidents reported in OP between September 2014 and August 15. Of these, 19 occurred on the SGH site. Thirteen of these were graded as very low, four as low and two as moderate.
- Since September 2014, the trust had reported five serious incidents (SIs) in ophthalmology, four at the Grimsby site and one at the SGH site. There had also been one never event in ophthalmology. There had been two serious incidents in other outpatient specialties. The SIs and never events reported were all related to delays in diagnosis. Delays in clinic appointments and missed follow up appointments were a recurring theme in the investigation reports into these incidents. The planned care manager told us they had not been involved in the SIs in ophthalmology, they explained these incidents were in the surgery division.
- Although the trust had investigated these incidents, at the time of the inspection it was unclear what actions the trust had put into place to prevent any future incidents occurring. Staff we spoke with were unaware of any changes to systems and processes. There was a

lack of urgency about taking actions following these SIs and never events; one senior member of the executive team told us, "There have only been five serious incidents in ophthalmology."

- The two moderate incidents both related to double and triple booking of appointments and overbooking of clinics, one in colorectal and one in urology. In the colorectal incident, the consultant had 12 patients booked in within one hour; three of whom were to be given serious diagnosis information, so therefore needed more time. As a result, medical staff were still seeing the morning clinic patients when the afternoon clinic was due to start.
- Staff we spoke with in urology and ophthalmology confirmed that overbooking and late running of clinics was a frequent problem in the OPD. The OP nurse manager there were regularly late running clinics in cardiology, renal and urology. This meant practice had not been changed in response to the moderate incidents, which had been reported.
- Staff confirmed incidents were discussed at staff meetings and that they knew how to report incidents.
- The clinical support services (CSS) management team told us they had no control over OP bookings and did not know why OP clinics were cancelled. They told us they would share any root cause analysis (RCA) reports via governance meetings, lessons learned newsletters, team briefs and quality and safety days.

Diagnostic Imaging

- There had been no serious incidents or never events in radiology at this site between August 2014 and July 2015.
- In the diagnostic imaging department, all staff were aware of hospital policies and procedures and knew how to report incidents. Staff told us they knew with how to report incidents on the hospital's 'Datix' incident reporting system.
- Between1 October 2014 and 8 October 2015 133 incidents had been reported in radiology at DPOW. The categories with the highest numbers of incidents were:
  - 11 Documentation (including records, identification);
  - 8 Access, admission, transfer, discharge other;
  - 7 Other incident to do with assessment;
  - 7 Documentation - delay in obtaining healthcare record / card
- Radiology staff we spoke with confirmed learning from incidents was discussed within the team and at team meetings.

Cleanliness, infection control and hygiene

Outpatients

- Clinical and non-clinical areas in OP appeared visibly clean and tidy, with equipment stored appropriately. One relative we spoke with told us they felt the OP department was always clean, they said, "They never stop cleaning." Staff told us domestic staff cleaned the department.
- In the fracture and orthopaedic OP clinic there were several carpeted areas, including waiting areas and clinical rooms. There were also carpets in the phlebotomy waiting room. This meant staff could not clean these areas to the required standard. We saw several carpets in a poor state of repair, and some with ingrained stains. The OP nurse manager told us they had raised this issue numerous times in the past and managers had told them there was no funding available.
- We observed a flask of water with a note saying, "Help yourself to a cool drink" in the OP waiting area. We found this flask was empty and the sticker on the flask indicated the flask was 'last filled on 4/11/2015. This was two days prior to our inspection of this area.
- We saw staff complied with infection prevention and control policies, for example wearing personal protective equipment (PPE) and participation in hand hygiene audits
- We reviewed the monthly hand hygiene audits between December 2014 and July 2015 and saw that all staff in OPD had passed the assessment; however, overall scores were not completed on the 'hand hygiene audit form.'
- In OPD at SGH between October 2014 and June 2015, hand hygiene audits showed 100% compliance every month.
- In August 2015 and saw that the OPD had an overall score of 92% on the trust's infection control and prevention (IPC) 'Frontline ownership audit tool.'
- We observed that the corridor where the consultants and medical secretary's offices were located had not been cleaned for some time. The carpets were dirty and

had a significant build-up of debris. When we asked staff working in this area about this they said they had raised the issue numerous times but there were no domestic staff allocated to that area.

Diagnostic Imaging

- Clinical and non-clinical areas in diagnostic imaging appeared visibly clean and tidy, with equipment stored appropriately.
- We reviewed flushing checklists for legionella requirements and saw these were all correctly completed and up to date.
- We saw staff complied with infection prevention and control policies, for example wearing PPE and participation in hand hygiene audits
- Summary information for hand hygiene audits in X-ray, CT, ultrasound and the blue sky imaging suite at SGH between October 2014 and June 2015 showed 100% compliance every month.
- There had been two infection control incidents reported between 1 October 2014 and 6 October 2015; both involved patients who should have been barrier nursed where the wards did not inform radiology of the patient's infectious status. There was no harm, injury or adverse outcome from these two incidents.
- Staff told us the department had achieved the 'IPC Gold Standard Award' two years running, in 2014 and 2015.

Environment and equipment

Outpatients

- The OPD at SGH was located on the first and second floors. Entry to the building was at ground floor level and there were lifts and stairs available. Ophthalmology and ENT clinics were located on the second floor.
- The facilities and premises were not appropriate for the services delivered. For example, there were very few designated waiting areas or rooms and we observed patients sat on chairs along the sides of the corridors. This made access for patients in wheelchairs, or with mobility aids difficult. Many of the patients visiting the ophthalmology department were visually impaired and came with relatives or carers. This meant there were often not enough chairs to accommodate everyone. We found the phlebotomy waiting area had sufficient chairs.
- One consultant said, "The waiting areas are not ideal; patients should not have to wait on the corridor."
- Staff told us patients sometimes had to stand because there were not enough chairs. Staff told us they would bring chairs out of offices where they could, but still some people often had to stand and wait. Many of the patients were middle aged to elderly and those visiting ophthalmology were visually impaired.
- We checked the three resuscitation trolleys and found medications were in date, all the checks were completed, and up to date, there was a paediatric trolley in the ophthalmology outpatient's area and one adult trolley on each floor.
- The OPD was clearly signposted within the hospital.

Diagnostic Imaging

- The facilities and premises were appropriate for the radiology services delivered there. The environment was clean, tidy, uncluttered, spacious and free from trip hazards.
- The trust had a register of equipment and the service reports we reviewed were all up to date.
- During the course of our inspection, we observed specialised PPE was available for use within radiation areas. Staff told us they were provided with appropriate PPE to undertake their role safely. Staff were seen to be wearing personal radiation dose monitors and these were monitored in accordance with legislation.
- Warning signs and restriction of access signs were all in place at all three sites. Restricted access areas were locked appropriately and signage clearly indicated if a room was in use. Patient changing facilities were appropriate.
- Resuscitation trolleys were all checked and in date.
- The radiology department was clearly signposted within the hospital.

Medicines

Outpatients

- We checked medicines storage in the OPD; all medicines stored were found to be stored securely and in date. However, records showed staff were not recording minimum and maximum fridge temperatures. Staff we spoke with were not aware of this requirement, although the record forms had columns for recording maximum and minimum temperatures.
- At the unannounced inspection (three weeks after the main visit) we asked the OP nurse manager whether staff had been told how to use the maximum and

minimum thermometers since the main inspection, they said, "We are still not recording maximum and minimum temperatures and we've not been told to do any different."
- We noted that medicines were stored at ambient temperature and the temperature of the room was not being monitored. The OP nurse manager had ordered a thermometer for this purpose when we revisited this area three weeks later.

Diagnostic Imaging

- We checked medicines storage in radiology; all medicines stored were found to be stored securely and in date. Controlled drugs were stored and the stock control was monitored and signed for correctly.
- Staff told us they did not carry out sedation at the SGH site.
- Records showed staff were not recording minimum and maximum temperatures of fridges where medications were stored. This was a trust-wide issue.

Records

Outpatients

- At the time of inspection, we saw patient personal information and medical records were managed safely and securely within the OPD. All patient records were paper-based.
- However, when we visited the corridor where the consultants and secretaries offices were we observed numerous sets of medical notes leaned up against the walls of the corridor. We were told us these sets of patient notes were from OP clinics and were waiting to be typed. The location of these notes was a fire risk and caused an obstruction to staff if they needed to exit the area in the event of a fire or other incident.
- We looked at the medical records of ten patients attending the ophthalmology outpatient clinic. We found these were of a good standard. They contained sufficient up to date information about patients including referral letters, copies of letters to GPs and patients, medical and nursing notes.
- We saw from incident records that staff would sometime see patients without their notes, if these could not be located. We saw examples where medical staff saw patients using only their referral letter. This meant there was a risk the staff member carrying out the consultation did not have all of the patient information required. Late in the morning of the last day of the visit, we heard OPD staff saying that they did not have any notes for that afternoon's clinic yet.

Diagnostic Imaging

- At the time of inspection, we saw patient personal information and medical records were managed safely and securely in radiology. The service used a combination of paper referrals, from GPs, and electronic referrals.
- Four sets of patient records reviewed in radiology, two CT, one fluoroscopy (nephrostomy) and one gastrostomy. No issues were identified.
- We found there was no documentation audits at the time of the inspection, the radiology manager added these audits to the annual audit schedule during the inspection.

Safeguarding

Outpatients

- Safeguarding training was mandatory for all staff in the department. According to the trust mandatory training submissions at 23 September 2015, the compliance rate for safeguarding training for OP nursing staff at DPOW was 100% for safeguarding children (levels 1 and 2) and 96% for adults. The trust target for training compliance was 95%.

Diagnostic Imaging

- The radiology department had safeguarding policies and guidance in place for both children and adults.
- Safeguarding training was mandatory for all staff in the department. According to the trust mandatory training submissions at 23 September 2015, the compliance rate for safeguarding training for all staff in the radiology department at SGH was 100% for safeguarding children (levels 1 and 2). Non-medical radiology staff compliance was 100% for safeguarding adults and medical staff compliance for safeguarding adults was 83%. The trust target for training compliance was 95%.
- Staff told us they used the hospital's Datix incident-reporting system for reporting safeguarding concerns.

- Staff we spoke with knew who the lead safeguarding staff in the trust were for children and adults. They were aware of their responsibilities regarding safeguarding and knew how to escalate any concerns.
- Staff told us they felt the local line managers were supportive, and said they had no problems escalating concerns.

Mandatory training

Outpatients

- Staff we spoke with told us their mandatory training was up to date. They told us they were notified when it was due for renewal.
- Mandatory training figures submitted by the trust showed overall compliance rates of 82% for information governance, 87% for equality and diversity, 85% for infection control and 85% for moving and handling. However, these figures were not broken down by hospital site or core service.
- Two clinic clerks we spoke with told us they had not received any specific training for their role. One said, "I started off doing patient transport bookings. I've learnt on the job." The trust carried out an RCA following our visit and this showed staff involved in the bookings process had not received appropriate training. This confirmed what we found during the inspection.

Diagnostic Imaging

- The deputy manager of radiology said all of the staff in the department were up to date with their mandatory training. Staff we spoke with confirmed this.
- Data submitted by the trust showed compliance rates for resuscitation training for medical, general, CT and ultrasound staff at the SGH site was 100%.
- Other mandatory training figures submitted by the trust showed overall compliance rates of 82% for information governance, 87% for equality and diversity, 85% for infection control and 85% for moving and handling. However, these figures were not broken down by hospital site or core service.

Assessing and responding to patient risk

Outpatients

- Domain not included in this inspection

Diagnostic Imaging

- Policies, procedures and local rules were in place in radiology; we observed that the local rules were on display.
- We observed diagnostic reference levels (DRLs) were available to staff in folders in the X-ray rooms. Risk assessments, including COSHH risk assessments, were all up to date.
- Radiology nursing staff told us they were responsible for the WHO surgical safety checklists. We found that radiology was using a modified version of the World Health Organisation (WHO) safety checklist and these were different in the different modalities; the CT checklists were different to those used in the other two areas. This meant the service was not following National Patient Safety Agency (NPSA) best practice.
- When we raised this to the managers, they told us the department would adopt this as standard across all modalities. They said the adoption of the NPSA standard would be proposed and discussed at the next governance meeting, scheduled for 28 October 2015.
- There were three separate waiting areas in the CT, MRI and ultrasound departments; we saw there were no staff in view of patients waiting in these areas. This meant there was a risk that staff would be unaware of a patient who needed staff attention.
- Management of deteriorating patients in radiology at all three sites used National Early Warning Scores (NEWS).
- All staff must were observed to be wearing body dosimeters (dose meters) on the front of their torso. A radiation dosimeter is a device that measures exposure to ionizing radiation. Staff told us they changed their dosimeters once a month. We saw the dosimeters were in date and had their expiry date on back.
- We reviewed recent reports from RPA inspection visits, IR(ME)R inspections and general X-ray system performance and radiation protection reports.
- Radiography staff were able to describe their responsibilities under the IR(ME)R regulations, how they would carry our pregnancy checks and how they would carry out patient identification checks.
- Staff told us the Radiation Protection Advisor (RPA) carried out a full audit every year. The RPA met with radiology staff in the trust bi-monthly.
- The manager told us the department had appointed and trained Radiation Protection Supervisors (RPS).

Their role was to ensure that equipment safety and quality checks and ionising radiation procedures were performed in accordance with national guidance and local procedures.

Nursing staffing

Outpatients

- There was a dedicated team of outpatient nurses, receptionists and support workers working in the OPD. The OP nurse manager said they did not manage the reception staff that work in the OPD.
- We reviewed the OPD staff rotas between 21 September and 18 October and 22 November to 22 November 2015. Due to the format of these rotas, we could not identify whether there were any unfilled shifts during this period.
- Staffing information submitted by the trust prior to the visit showed there were 14.56 WTE nurses in post in the OPD at bands 5 to 8 and the establishment was 13.38 WTE. There were 26.15 WTE staff at bands 1 to 4 in post and the establishment was 27.07. Total staffing establishment was 40.45 and there were 40.71 WTE in post, leaving a shortfall overall of 0.26 WTE.
- However, on the last day of the inspection (unannounced) the OP nurse manager told us they had vacancies within the department for two staff nurses, who had recently left.
- The ophthalmology clinical lead told us, "Every week there are six or seven different versions of the staff rota, it makes it impossible for X (OP nurse manager's name) to staff the clinics." The OPD did not use an acuity tool and the OP nurse manager told us, "We work on short notice all the time. I'm firefighting eight hours a day; it's wearying."
- The OPD did not use any bank or agency nursing staff and occasionally used bank support workers. Staff told us retention was good in OP and staff turnover was low.

Pathology staffing

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

Clinical administrative staffing

- Clinical Administration Support Team (CAST) office staff told us there used to be nine staff in the team, they said staff had left and not been replaced They said there was four or five staff in the CAST office most days. Staff had to book appointments and answer the phone; they told us there were 200 to 300 calls a day and they could not answer them all. When we asked whether the call handling in the office was monitored the staff were not aware of whether it was or not. They told us, "The phone calls are all different in the contact centre (CAST bookings office); eyes will be separate in the new scheme of things." They said they thought that would work better as all of the relevant specialty staff would work together in the same location.
- On the last day of the inspection, a clinic clerk from the CAST team confirmed that, "A lot of calls go unanswered now."

Diagnostic Imaging

- There were sufficient numbers of appropriately trained and skilled staff to meet patients care and treatment needs in radiology. Radiology did not use any agency staff.
- Staff told us there were 31 radiographers working at the SGH site, some rotated through CT, mammography and MRI specialisms.
- The SGH was carrying three WTE radiographer vacancies, which were being covered by the team.
- Radiology staffing information submitted by the trust was for radiology across all three sites. The total number of staff in radiology was 223.32 including 11.8 medical staff. Non-medical staff included radiographers, qualified nurses, healthcare assistants and clerical staff.
- The radiology manager told us the department did not use any bank or agency staff.
- The department worked with the local college to support and train radiographers, using a bursary-type scheme.
- Staff told us, and trust records confirmed, that the radiology department did not use bank or agency staff.

Medical staffing

Outpatients

- Medical staffing for OP clinics along with clinic capacity and demand were managed within each clinical division, such as medicine and surgery. The divisions reviewed and managed their own mandatory training, appraisal and revalidation for medical staff.

Outpatients and diagnostic imaging

- We spoke with two ophthalmology consultants (one of which was the clinical lead for the service). They said the clinics were very busy and that demand exceeded capacity.

Diagnostic Imaging

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

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

- Radiology policies, procedures and audits complied with national regulations and standards. The service monitored radiation exposure, participated in relevant audits and held discrepancy meetings.
- All patient appointments were within six weeks of their referral. Staff could access patient information, such as x-rays and medical records, easily. Medical records were a mixture of electronic and paper records.
- Staff in radiology received appropriate training and professional development to carry out their roles and there was evidence of good multidisciplinary working. Radiology nursing and general staff were just below the compliance target of 95% for their annual appraisal.
- The service operated a seven-day 24-hour service, apart from in MRI where there was no out of hour's service. Radiologists provided an on-call service outside normal working hours. The service had clear consent procedures, which the staff followed.

Evidence-based care and treatment

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- Policies and procedures were available on the trust intranet. These complied with Radiology Protection Association (RPA) and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) guidance and requirements. These included procedures:-
  - To identify correctly the individual to be exposed to ionising radiation (the three stage identification check)
  - Making enquiries to establish whether female is or pregnant or breastfeeding
  - To ensure clinical evaluation of medical exposures
  - To minimise patients receiving accidental unintended dose ionising radiation
- Procedures for scanning were based on NICE (National Institute for Health and Clinical Excellence), Royal College guidelines and best practice guidance. For example, the department had IPC policies and procedures.
- The trust had an annual plan for audits in radiology, this included audits relating to IR(ME)R. Staff told us their next IR(ME)R audit was due to be completed in February 2016. The trust had an IR(ME)R inspection report every three years.
- The IR(ME)R trust wide audit on compliance with IR(ME)R report from March 2015 showed 'significant assurance' that the guidance relating to ionising radiation regulations were being followed.
- Results of this audit showed an improvement in the results for clinical evaluations being present in the notes compared with previous audits. The results from previously audited areas have improved across the trust with compliance of more than 90% at each site; SGH compliance had improved from 78% to 93%.

Patient outcomes

Outpatients

Outpatients and diagnostic imaging

- Domain not included in this inspection.

Diagnostic Imaging

- Between 1 October 2014 and 30 September 2015, the diagnostic imaging department saw 157,450 patients at the SGH site. Radiology waiting time data submitted by the trust showed 99.96% patients attending the SGH site were seen within 6 weeks of their referral. Sixty patients waited six weeks for their appointments and one patient waited seven weeks.
- The diagnostic department undertook a range of national statutory audits to demonstrate compliance with the radiation regulations. For example, diagnostic imaging had a procedure for the use of diagnostic reference levels (DRLs). We saw that the RPA audited DRLs; records reviewed showed compliance was good overall.
- The service was aware of recommended national reference doses for radiation exposure. Diagnostic reference levels were an aid to optimisation in medical exposure. We observed that DRL exposure checks and local rules were on display.
- We reviewed an example of a CT audit across two different hospital sites, SGH and DPOWH, carried out on 25 September 2015. This audit showed that overall DRL compliance was good. However, there were some differences in doses across the two hospitals and some doses had increased since the last audit. There were actions for the RPS to take to optimise the relevant protocols and the audit was due for review in October 2016.
- The radiologists held regular discrepancy meetings; this showed the department complied with Royal College of Radiology (RCR) Standards. We reviewed a monthly audit report for June 2015 by the external company carrying out outsourced CT work. This showed any discrepancies were forwarded to the radiologists and the report was reviewed at the discrepancy review meetings.
- All patients in this audit had their radiation dose recorded on the RIS; this was an improvement from the last audit where this figure was 61%.

Competent staff

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- Managers told us formal arrangements were in place for induction of new staff and rotating radiographers. Rotating radiographers had their own induction packs and we reviewed these documents. Managers signed off staff induction documents on an ongoing basis.
- There were bespoke induction packs for different grades of staff. Radiography staff we spoke with were able to describe the local and trust induction procedures.
- Staff told us they were encouraged to undertake continuous professional development and that this was supported within the department. Staff said they were given opportunities to develop their clinical skills and knowledge through training relevant to their role
- Radiation Protection Supervisors (RPS) were trained externally. The RPA at another local NHS trust was developing an e-learning programme to assist with ongoing training and updated for the RPSs.
- At the time of the inspection, the service was undertaking some partnership working with a nearby trust to look at training more radiologists and strengthening the service with their support. There was a Service Level Agreement (SLA) with the nearby trust to provide radiation protection and medical physics expert cover; radiologists we spoke with confirmed this.
- Radiologists had a formal process of appraisal and regular contact with the other trust radiology departments, including telecom meetings every fortnight.
- Staff we spoke with told us their appraisals were up to date. Information submitted by the trust showed performance and development reviews (appraisals) for medical staff in radiology at the SGH site were 100% compliant.
- Appraisal rates for non-medical staff in radiology were 89% for CT staff, 92% for general radiology staff and 78% for ultrasound staff. The trust target was 95%.

Multidisciplinary working

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- We observed good working relationships between radiographers, radiologists, managers and support workers and administrative staff within the department.

Seven-day services

Outpatients and diagnostic imaging

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- General radiology provided a 24-hour seven-day service with core hours from 8.30am to 5pm and reduced staffing (2 radiographers and 1 HCA) outside these hours.
- CT was open from 7.30am to 8.30pm with on call outside these hours for non-stroke cases (30 minute response time). A 24-hour seven-day stroke cover service was provided on site
- MRI was open from 7.30am to 10.30pm seven days a week with no out-of-hour's cover. On Saturdays and Sundays, MRI was open from 7.30am to 8.30pm.
- Ultrasound was open 8am to 6pm seven days a week and the radiologist provided emergency cover out of hours.

Access to information

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- Staff received training in the Mental Capacity Act and data submitted by the trust showed 100% compliance with this training in ultrasound, 91% in general radiology, 75% in CT and 100% for radiologists at the SGH site. The trust's training compliance target was 95%.
- Staff we spoke with understood the consent procedures in radiology. They told us if a patient could not identify himself or herself, for whatever reason, the procedure would not proceed.
- Staff explained that consent for procedures was implied, and patients were not required to sign to confirm their consent.
- Staff told us that if a GP referred a patient to the department and there was no clinical history then they would return the referral and request more information.
- For hospital inpatients, staff explained that they would check the patient's wristbands. Referrals from the inpatient wards were electronic.
- Four sets of patient records reviewed in radiology, two CT, one fluoroscopy (nephrostomy) and one gastrostomy. Confirmation of consent was present in the records we reviewed, and was correctly completed.

Are outpatient and diagnostic imaging services caring?

Good

We rated the service as 'good' for caring because:

- Staff in outpatients and radiology demonstrated a good level of rapport in their interactions with patients and relatives.
- We spoke with 12 patients and three relatives in the outpatient waiting areas and five patients in the radiology waiting areas. Patients all told us all of the staff were caring, friendly and helpful. We heard staff introducing themselves to patients.
- Patients and relatives told us staff involved them in their care and treatment, and they understood why they attended the hospital. They said staff provided appropriate emotional support and reassurance when they needed it.

Compassionate care

Outpatients

- We spoke with 12 patients and three relatives in the general OP waiting area and in the ophthalmology waiting area and they gave mixed feedback about the

service provided. However, they were all positive about the care they received from all staff. They told us the staff were caring and there were enough staff. One patient said, "The nurses are really nice here."
- One patient said, "This hospital is pretty decent" and another said, "The hospital is really good." Three out of 12 patients said they had "no complaints" while others told us of their problems with clinic cancellations, getting through on the phone, accessibility and continuity of care.
- We overheard an elderly female patient with a walking aid become very distressed when they arrived to book in at the reception desk and the receptionist told them their clinic appointment was cancelled. They said they had a serious medical condition, which affected their mobility, and their 88-year-old husband had brought them in to the hospital. We observed the lead consultant, OP nurse manager and staff arrange for one of the ophthalmology consultants to see this patient on the same afternoon.
- Staff we spoke with, including medical staff, told us they felt patients got a good service. One consultant said, "We want the patients to be happy."
- We observed staff greeted patients respectfully and kindly at the reception desk. We also heard patients laughing and joking together and staff apologising when patients' appointments were late.

Diagnostic Imaging

- We spoke with five patients in the radiology waiting areas. Patients all told us they were happy with the service. Three said there were "no issues" and one said they had received, "Excellent care in radiology."
- We heard staff talking with patients in a polite and courteous manner and reception staff greeting patients in a polite and courteous manner.
- We reviewed patient feedback comments; 36 responses had been completed from 100 forms given out to patients in plain X-ray and interventional radiology. We saw all of the comments were positive and included, "The best NHS appointment I've ever had" and "I wish the rest of the hospital was as efficient."

Understanding and involvement of patients and those close to them

Outpatients

- When we asked patients and relatives whether they understood their care and treatment, the responses were mixed. One patient and their relative said that treatment had been explained effectively. Another patient and their relative said, "Dr X (name) is brilliant" when they were asked about medications and whether the risks and benefits had been explained to them. We also overheard a nurse explaining a procedure to a patient, which they were due to have that day.
- However, one patient told us their last procedure was an injection; they said, "I wasn't even told that I was having an injection." We heard a staff member telling a patient that they were to have, "an FFA test." The patient asked the staff member to explain what was meant by an FFA test, as they did not understand that term.
- One patient said they would like the appointment letters to say whom they would be seeing and what procedure they would be undergoing.
- Another patient's relative told us the GP had stopped the patient's eye medication, which had seemed to be helping their condition, but they did not know why. They said, "We have an appointment with an ophthalmologist but it's not for another three weeks."
- Leaflets giving information for patients and visitors were available and easily accessible. For example, in the ophthalmology department we saw information about 'floaters and flashers' and the fluorescein angiography eye test.

Diagnostic Imaging

- We spoke with five patients in the radiology waiting area and their feedback about understanding and involvement was all positive. They all said the staff had explained their procedures clearly and they understood the processes.

Emotional support

Outpatients

- We observed and heard staff speaking with patients in a kind and caring manner.
- Patients told us they were happy with the care and support from staff. One patient said, "The staff are open to me asking questions."
- In the main OP waiting area, we saw information on display about:-
  - a cancer support group

- how patients could request a copy of the letter the OP department sent to their GP
- A 'fast track clinic.'

- There were also communication boards on display in the OPD; these showed patients which doctors were on the clinics for that day.

Diagnostic Imaging

- Staff were heard introducing themselves to patients. We observed that all staff (radiologists, radiographers and support workers) talked kindly to patients and reassured them during their procedures.
- Ward staff assessed whether inpatients required chaperones in the X-ray department; we observed that not all inpatients had chaperones with them while waiting in the department.

Are outpatient and diagnostic imaging services responsive?

Inadequate

We rated the service as 'inadequate' for responsive because:

At the last inspection in April 2014, we rated outpatients as requires improvement for being responsive. This was because the hospital had a relatively high did not attend rate (10.7%) and high levels of cancellations of outpatient appointments (18%). At this inspection we rated this service as 'inadequate' for being responsive because:

- There was a trust-wide backlog of 30,667 outpatients without follow-up appointments, the majority were in ophthalmology and there were five known incidents of harm to patients as a result. The trust had identified some of the issues, specifically ophthalmology, in March 2015 and actions to improve the backlog were in progress at the time of the inspection. However, these had not been effective in significantly improving the position. At the time of the inspection the service had no robust action plan to address the immediate clinical risk to patients due to delays in patients receiving care and treatment. We asked the trust to act on this immediately. Following the inspection, they provided weekly updates and in January 2016 told us that all patients in this backlog had now been validated and either discharged, given an appointment or were identified as waiting for an appointment in the future.
- We found the 'did not attend' (DNA) rates in OP had improved slightly since the last inspection but cancellation rates had increased. Between October 2014 and September 2015, the did not attend rate in OP overall was 10.3% and the did not attend rate in ophthalmology for the same period was 8.0%,
- The level of list cancellations for OP appointments was 21% in 2014/2015 and 22% between April and September 2015, compared with 18% at the last inspection. Cancellation rates were higher in ophthalmology; between September 2014 and August 2015, 23.9% of ophthalmology clinic lists were cancelled. Patients did not have a positive experience because of problems with repeated appointment cancellations in outpatient clinics. We saw evidence of this during the inspections. The administration system for outpatients lacked oversight by clinicians and experienced staff. We found that clinic clerks cancelled whole clinic lists, or part of clinic lists with no guidance about clinical priorities or clinical triage.
- Workload pressures and loss of staff meant there was a lack of robust and timely validation of the follow-up position for outpatients' appointments. The ongoing 'clinical admin review' meant many band 3 staff across the trust had left, including medical secretaries. Fewer staff in the central data quality team meant they could not monitor follow-up in outpatients.
- Referral to treatment (RTT) performance for admitted and non-admitted pathways at the trust had been above the standards and the England average since April 2013. Data indicated that cancer waits had been consistently better than the England average since Q1 2013/14. This meant that in the main patients waited less time for these particular appointments.
- The OP service did not have reliable systems or processes to meet the needs of different patient groups. This included those in vulnerable circumstances or with additional needs. We identified concerns in outpatients relating to the privacy and dignity of patients in the outpatient and radiology waiting areas.
- We spoke with 12 patients and three relatives in OP clinic waiting areas, including ophthalmology. Every patient we spoke with told us they had experienced at least one cancelled appointment. They also told us

appointment times regularly ran late. Staff and patients also told us patients turned up for appointments which had been cancelled, because they had not been informed of the cancellation.
- The service received a high number of formal and informal complaints about the service because of the problems with appointments and follow up.

Service planning and delivery to meet the needs of local people

Outpatients

- The service had increased capacity by running OP clinics out of hours and at weekends for several months, to ensure patients had their appointments booked and to reduce the backlog.
- One patient complained that they had seen seven different consultants in the past year, they said, "There is no continuity of care." They also said their glaucoma had only been diagnosed after several visits to ophthalmology to discuss other conditions. A relative told us, "My wife has a long term condition; there is no continuity of care. We are not sure what will happen next." This showed patients felt the service did not provide continuity of care.""
- Several patients and relatives told us about problems contacting the hospital by telephone about their appointments, while other patients told us they had been able to get through to the eye clinic by telephone without any problems.
- Since the last inspection, outpatients had introduced a reminder system using text messages for patients and the ophthalmology department was piloting call reminders, to ensure patients were aware of their appointments. The OP nurse manager said the did not attend rate should be improving, now patients were being texted about their appointments. However, the OP nurse manager was unaware whether the did not attend rate had actually improved in their department or not.
- One patient told us they had been unable to receive their treatment as, "the machine had broken down." We heard staff trying to rearrange this patient's treatment at another hospital, however they were unable to do this and told the patient they would contact them the following week.
- Staff told us patients received a 'what happens in ophthalmology leaflet with their appointment letters. They said this told patients to expect a two-hour wait.
- The clinical lead in ophthalmology told us they had started sending their clinic consultation letter to the GP and to the patient. They said they wanted to roll this out across the three hospital sites.
- Staff in ophthalmology OP told us they would prioritise patients who were using the hospital transport if they could.

Diagnostic Imaging

- Mobile vans, which were open 24-hours a day seven days a days a week increased the capacity within radiology and ensured radiology met its patient access targets.

Access and flow

Outpatients

- At the time of the inspection there was a trust-wide backlog of 30,667 outpatient patient episodes which potentially had missed appointments and needed a follow up but did not have a date. The majority were in ophthalmology and there were five known incidents of harm to patients as a result. The trust had identified some of the issues, specifically ophthalmology, in March 2015 and actions to improve this backlog were in progress at the time of the inspection. However, these had not been effective in significantly improving the position. At the time of the inspection there was no robust action plan to address the immediate clinical risk for all the specialities leading to delays in care and treatment. We asked the trust to act on this immediately. Following the inspection, the trust provided weekly updates and in January 2016 told us that all patients in this backlog had now been validated and either discharged, given an appointment or were identified as waiting for an appointment in the future.
- Referral to treatment (RTT) performance for non-admitted patients had fallen since April 2013, but had remained above the 95% standard and the England average throughout this period.
- Referral to treatment performance for incomplete pathways had been between 96- 98% since April 2013, above the standard of 92% and the England average.

Outpatients and diagnostic imaging

- All cancer waiting time measures had been consistently higher than the England average since Q1 2013/14. This meant patients waited less than the national average for their appointments.
- During this inspection visit, we found the DNA rates and cancellation rates in outpatients had not improved since the last inspection in April 2014.
- We reviewed the trust's 'Referral to treatment access policy' and found that the trust target for outpatient clinic cancellation and did not attend rates was 6%.
- Between September 2014 and August 2015, the did not attend rate was 10.3%. The level of list cancellations in outpatients remained high and had increased since the 2014 inspection; the cancellation rate was 21% in 2014/2015 and increased to 22% between April and September 2015
- In ophthalmology during the same period the did not attend rate 8.0%, this amounted to 2115 patients. The clinic cancellation figures in ophthalmology for September 2014 to August 2015 were 23.9%
- Waiting times for outpatient appointments at all three trust sites showed there were 116,535 first appointments between October 2014 and September 2015 and 28% (32930) of patients waited more than six weeks for their first appointment.
- Data provided by the trust showed 67.97% of OP referrals had been seen within six weeks in August 2015, against the national target of 90%.
- The admitted RTT was 76.57% against the national target of 90% and the non-admitted RTT and incomplete pathway targets were both being met.
- We found the OP department was putting on extra clinics at short notice, however we found this was not convenient for everyone
- We spoke with 12 patients and three relatives in OP clinic waiting areas, including ophthalmology. Every patient we spoke with told us they had experienced at least one cancelled appointment. They also told us appointment times regularly ran late. Staff and patients also told us patients turned up for appointments which had been cancelled, because they had not been informed of the cancellation.
- Comments from patients and relatives in the OP waiting areas included:
  - "They just keep cancelling appointments; this is the third time."
  - "Appointments are okay; we had one cancelled but they brought it forward to today."
  - "We have never had any appointments cancelled."
  - "I was phoned by the hospital yesterday to come in today, however when I arrived staff had no record of my appointment."
  - "I came in July and should have had an appointment in September. I did not hear anything until they called me with an appointment yesterday. They have put an extra clinic on."
  - "My first appointment was cancelled and I have had to wait 12 weeks for an appointment since diagnosis."
  - "Friday is not a good day for me as I am self-employed and Fridays are a busy day, but they wouldn't change it."
  - I should have had an appointment for later this month, they phoned me yesterday and asked me to come in today."
  - "I once had three appointments cancelled on the trot. Once I was phoned when I was travelling in to the hospital."
  - "My wife had an appointment cancelled; the new one was months ahead."
  - "The doctor was angry when he found out our appointments had been cancelled. They (clinic staff) aren't aware of what is happening."
- One patient told us they had requested not to have an appointment during their holiday, and had provided the dates when they were unavailable. When the appointment came it was for when they were away, this was in the summer of 2015.
- We found waiting times for patients once they have arrived in the department were variable. On the day, we spoke with patients several told us their appointments were running 30 to 40 minutes late. One patient told us, "If you come as an emergency patient it can be two or three hours." Staff told us patients regularly waited a long time, especially in urology.
- Most patients told us, and we overheard, that staff advised them when the clinics were running late. Several patients told us staff had informed them appointments were late running late that morning. However, one patient said, "They don't normally tell you if they're running late."
- Staff told us the urology clinics were, "Regularly running one to one and a half hours behind."
- We saw there was one receptionist at the ophthalmology reception desk during the afternoon of our visit; the reception was very busy. Several staff,

including an ophthalmology consultant, told us they felt there should be two reception staff on this desk. Staff told us the receptionist had to book patients in, answer the phone and book appointments. This caused a bottleneck in the system.

- We observed there was a queue for 20 to 30 minutes at the beginning of the afternoon clinic. We saw many elderly people, some with mobility problems, stood waiting in the queue to book in for some time. Staff told us patients also had to report to the reception desk before they left, to book their next appointment.
- On the last day of the inspection, a clinic clerk told us a new version of the trust's access policy was due to be issued. They said, "There's a new process and we're all sticking rigidly to it now."
- They also said they were getting a clinical cancellation sheet and an impact assessment form now. They added, "That didn't happen before; there were more without the form that with it before the changes."
- Cancelled and rearranged clinics and appointments were a major issue for staff and patients. This caused a lot of inconvenience, especially to elderly and vulnerable patients.
- The OP nurse manager told us the department needed, "A more robust process; the clinic change form needs to be reintroduced." They said late notice annual leave for medical staff was part of the problem."
- We found one clinic had been cancelled on the final day of our visit; this was due to consultant sickness. The OP nurse manager told us five clinics for the following Monday, had been cancelled on the Friday morning. This was because managers had arranged some 'time out' sessions for the consultant staff. This meant short notice changes to staffing for these five Monday clinics and short notice phone calls to a large number of patients cancelling their appointments.
- The OP nurse manager told us they never knew whether doctors were going to turn up to clinics or not. They said the service managers and team leaders should give four weeks' notice about clinics. They said they usually got four days' notice.
- Nursing staff said patients regularly turned up for clinics that had been cancelled; they said this was, "very frustrating." The OP nurse manager told us they would complete a Datix incident when this happened.
- The OP nurse manager said that clinic slots were, "Regularly double and triple booked." Staff told us patients often told them their appointments had been cancelled multiple times. When we asked the service managers and team leaders about multiple cancellations they said, "There should be free text comments to show that a patient has been cancelled previously," however this depended on staff completing the free text comments, which were not mandatory.
- Patients and staff also told us patients were often told that they had cancelled an appointment, when the hospital had cancelled it. We found the system for recording whether the patient or the hospital had cancelled an appointment was not reliable.
- Staff in the CAST bookings team told us they did, "Not have the capacity to think about whether a patient had been cancelled previously."
- They also told us ophthalmology first appointments were currently being booked 13 weeks ahead and urology appointments six to eight weeks ahead. They said the Patient Tracker Lists (PTLs) had, "Hundreds of patients waiting for first appointments for ophthalmology and probably thousands for ophthalmology follow-ups."
- On the last day of the visit, we asked clinic clerks about the cancellation process and the priority status of patients. They told us, "There is no priority status; you have to go by the comments. For example, three-week follow up after injection. You try to pick ones that haven't been cancelled before."

Phlebotomy

- We found the phlebotomy waiting area was located immediately adjacent to the pathology laboratories; this meant there was no delay in getting sample to the laboratory for testing. The phlebotomy waiting area had toilet facilities, including disabled toilets.

Ophthalmology

- There were ongoing capacity and demand pressures in ophthalmology resulting in:
  - Failure to meet 18 week targets
  - Delays between follow up appointments, resulting in patient incidents
  - Unable to meet national standards and guidance required
  - Cancelled appointments
  - Poor patient experience evidenced through high numbers of complaints
  - Ophthalmology outpatient referrals numbers increasing

Outpatients and diagnostic imaging

- Progress had been made to reduce new to review ratio and increase patients through theatre. In 2012/13, the new to review ratio was 4.0, decreasing to 3.7 in 2013/14 and 3.3 in 2014/15.
- There were high numbers of on the day patient cancellations and on the day hospital on the day cancellations. There had been no significant improvement in follow up appointments being timely.
- Of 3032 letters, which had been identified as a backlog in ophthalmology, 1187 letters were outstanding as at August 2015 trust wide with 1483 patients remaining to be seen. 305 were to be seen at Scunthorpe Hospital, with 11 clinics scheduled to take place in Scunthorpe to address this.
- The ophthalmology OP follow up position in August 2015 was:-
  - 3601 overdue not booked
  - 2133 Unknown not booked
  - 2179 booked and overdue
  - 1340 booked and unknown
- Previous growth trends identified an increase in inpatient activity and a decrease in outpatient new appointments and this was expected to continue in 2015/16. However, patients remaining in the follow up system due to chronic disease were increasing. Additionally, growth on the 18-week waiting list had increased substantially year on year since 2012/13 and continued to create pressures on service delivery.
- Trend analysis demonstrated that the ophthalmology service received an additional 250 new referrals extra each year, and there has not been an increase in established posts or physical footprint to meet this increased demand for a number of years
- Ophthalmology saw 1100 patients per week on average and each patient was typically seen for four review appointments before going on to be discharged or reviewed for life due to the nature of their condition.

Diagnostic Imaging

- Between 1 October 2014 and 30 September 2015 radiology at the SGH site undertook; 18023 Computed Tomography (CT) scans; 3959 fluoroscopy; 8368 Magnetic Resonance Imaging (MRI) scans; 27872 ultrasound and 60251 X-rays.
- Waiting times for radiology appointments showed that out of 103,991 appointments. 0.07% (74) of patients waited more than six weeks for their appointment, between October 2014 and September 2015.
- We observed there was a bottleneck of inpatients waiting for escorts to take them back to the ward areas in the main general X-ray waiting area. There were no other issues identified with access and flow within the radiology departments visited; waiting rooms did get full, but the patient flow was maintained.
- We reviewed waiting turnaround times and reporting times for examinations performed at all three sites. Waiting turnaround times / examinations for radioisotopes was 26 days and the reporting time was just over 200 hours. When we discussed this with the managers, they were aware of the issues.
- We spoke with five patients in the radiology waiting areas; they all told us their appointments had been on time.
- Data submitted by the trust showed performance against the eight national and local cancer targets was compliant in six out of the eight categories in July 2015. The two categories which were not compliant were:-
  - 62-day wait urgent GP referral to treatment was 80.42% against the national standard of 85%
  - 62-day wait consultant screening service was 84.62% against the national standard of 90%.

Meeting people's individual needs/ accessing care and treatment in a timely way

Outpatients

- The OP service did not have reliable systems and processes in place to meet the needs of different patient groups, including those in vulnerable circumstances or with additional needs, such as those living with dementia or a learning disability.
- The OP department was accessible to patients with disabilities; there was a lift to the first and second floor from the ground floor OP entrance. We observed wheelchairs were available at this OP entrance and staff told us there was a wheelchair in the OP department. However, there was limited space to manoeuvre wheelchairs, mainly due to chairs arranged along the corridors. The main OP waiting area had four spaces designated for wheelchairs. We observed three people in wheelchairs on an afternoon clinic; the waiting room was not busy. Staff told us there was a 'turn-aid' for assisting patients in and out of their wheelchairs. They said there was hand-held equipment available for patients who could not get out of their wheelchair easily.

- The OP nurse manager told us there was no separate list or waiting area for paediatric clinics. We saw there was a small children's play area adjacent to the main OPD waiting area.
- Staff told us patients with complex needs, such as dementia, learning disabilities or autism, would be highlighted on the clinic lists if staff were made aware in the referral letter.
- The ophthalmology clinical lead said they asked GPs to inform them about patients with special needs in their referral letters but this did not always happen. They said they had recently dealt with a complaint about this issue. We saw patients waiting on chairs along the corridors outside the consultation rooms; staff explained this was due to a lack of waiting room space.
- While we sat in the OP waiting area we found we could overhear conversations in the clinic consultation room opposite. This meant privacy could not always be maintained during consultations between consultants and patients in this area.
- In the ophthalmology clinic we observed the reception desk had a freestanding notice which said: - To allow patients confidentiality please wait here until the receptionist is free.' This showed the service respected people's privacy when holding conversations with reception staff.

Phlebotomy

- The pathology site manager told us the phlebotomy service would prioritise patients in order of clinical need, such as diabetic patients attending the diabetic centre or patients on warfarin. They said children had blood samples taken in paediatric OPD and teenagers were seen by appointment in phlebotomy.

Diagnostic Imaging

- Staff we spoke with were aware of the procedures when dealing with patients with special needs; they told us patients with learning disabilities or dementia and children would be fast-tracked. Ultrasound staff told us people with learning disabilities or dementia would require a chaperone and radiography staff were able to describe how they would manage patients with special needs.
- We asked staff about interpretation services; staff in sonography and radiology were aware of how to access these.
- We saw there was a private waiting area for GP patients. However, we observed patient privacy and dignity issues in some of the radiology waiting areas. For example, there were inpatients laid in beds waiting next to the examinations waiting room, with their oxygen cylinders. These patients did not have curtains drawn around them. This exposed inpatients to other ambulant patients and members of the public, as they had had to walk past them to access other waiting rooms. Other patients did not have their bed covers fully pulled over them and some inpatient beds were in bays with curtains available but the curtains were not closed.
- When we asked staff about this, they said patients did not like the curtains drawn. However, it was unclear whether staff had asked the patients about their preferences. We also saw three patients sat in wheelchairs in their dressing gowns; we felt this did not protect their privacy and dignity.
- When we brought this to the attention of senior managers in the department they said they said would review urgently.

Learning from complaints and concerns

Outpatients

- We observed a notice on display in the OP waiting area telling patients how to make a complaint.
- Between the 1 April and the end of October 2014, 154 complaints received by the trust via the patient advice and liaison service (PALS) complaints, the vast majority related to the administration of appointments. This was consistently high in comparison to other specialties and higher at this site. In the same period, there had been nine formal complaints, the majority related to the administration of appointments.
- Information provided by the trust dated July 2015, showed between 1 April and 31 July there had been 198 complaints received via PALS, 14 formal complaints and 5 SIs in ophthalmology.
- No formal complaints had been received in OP at the SGH site between 1 October 2014 and 6 October 2015.
- Staff in ophthalmology told us they would deal with concerns and complaint 'as they arose' in the clinics, they said they were not involved or aware of any complaints. Managers also said complaints and concerns "would be dealt with there and then" but did not say how they would record this.

Diagnostic Imaging

Outpatients and diagnostic imaging

- Complaints were handled in line with the trust policy. The trust had received five formal complaints relating to radiology at the SGH site between 1 October 2014 and 6 October 2015. Three related to the standard of care, one related to waiting times and one related to staff attitude.

Are outpatient and diagnostic imaging services well-led?

Inadequate

At the last inspection in April 2014, we rated outpatients as 'good' for being well led. During this focussed inspection, we identified significant concerns in outpatients, which the leadership team had failed to fully recognise and address. We rated the service as 'inadequate' because:

- The delivery of high quality patient care was not assured by the leadership, governance or culture in place.The trust did not have effective arrangements to monitor, recognise and act on the issues we found with outpatients appointments. Patients had been harmed and there was a continuing risk that patients would not receive good quality care. There was no effective system for identifying, capturing and managing risks.
- Following our inspection, we wrote to the trust on 25 October 2015 detailing the significant concerns we found in outpatients services during the visit. The concerns related specifically to the OPD follow-up backlog, the high level of cancelled appointments, appointments cancelled on the day and evidence of appointments being cancelled without clinical input in to decision making.
- The trust acknowledged that the management and monitoring of OP waiting lists urgently required improvement, especially in ophthalmology.
- The trust assured us they would take urgent action to clear the backlog of OP appointments, and monitor clinic cancellations and unanswered phone calls going forward. The ongoing clinical admin review was part of the trust's action plans and this was due to be completed by the end November 2015.
- The trust did not have a culture of continuous evaluation and quality improvement. They did not provide robust evidence to show they asked staff or patients for feedback on the service.
- Leaders were out of touch with what was happening on the front line.The trust did not communicate effectively with the staff working in outpatients. For example, they told us about their visions and plans but staff we spoke with in the service did not know about these, when we asked. Staff heard about work to improve capacity and demand but the trust did not involve them in this work or share their plans.
- In outpatients and the clinical administration support team, there were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported and appreciated by their senior managers.
- However, staff in both outpatients and radiology told us their local line managers supported them. They said local managers were visible and provided leadership. Staff and managers told us there was an open culture. They felt empowered to express their opinions and felt that they were listened to.

Vision and strategy for this service

Outpatients

- Senior managers in CSS and the executive team talked about visions and plans, but these had not communicated these to staff working in the OPD.
- The trust was working closely with the commissioners to address the significant capacity and demand issues within ophthalmology. The trust Governance and assurance committee (TGAC) update from July 2015 showed all 11,500 ophthalmology patients had been validated, with just over 3000 patients requiring a follow up appointment.
- There had been an 'Ophthalmology deep dive' in February 2015. The main findings showed unbalanced job plans against pay budget, high did not attend rates, opportunities to complete more elective cases and high on day cancellation rates.
- Assurance and overview of the entire ophthalmology improvement plan, including equipment, workforce changes, and pathway design was being undertaken through the monthly business meetings with the entire ophthalmology team led by the clinical leader and the CSS assistant general manager (a medical consultant). The 'ophthalmology backlog action plan' included surgery and outpatient follow up clinics.

- The clinical admin review was ongoing at the time of the inspection and band 2 and band 3 staff were expecting to hear where their new roles were allocated to within the following two weeks.
- Nursing staff in ophthalmology told us there were plans to have dedicated clinics to manager stable long-term conditions, such as glaucoma and diabetes, in the future.
- When we asked senior nursing staff and medical staff about sustainability, capacity, and demand, they knew some work was in progress but they could not tell us any details. This showed the executive team were not sharing their high-level plans with the staff providing the services.

Diagnostic Imaging

- Diagnostic imaging was part of the clinical support services (CSS), which managed radiology services across the three hospital sites. The head of radiology services was accountable to the associate medical director and associate chief operating officer. Clinical support service also had a business manager and two business support managers.

Governance, risk management and quality measurement

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

Letter to the trust following the inspection

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

The inspection team found:-

1. There was no monitoring of patients with multiple cancellations and no audit of clinic cancellations.
2. Significant gaps in the assurance process and assessment of managing clinical risk. For example, another SI was identified during the inspection week of a patient post corneal graft.
3. Systems and processes to provide information to booking staff as to whether patients have had previous cancellations were not robust.
4. Systems for booking clinics were multi-step and fell between different specialties and administration groups. This meant no one had ownership or responsibility for the process.
5. Lack of administration staff in the CAST (bookings) team at both the DPOWH and SGH sites meant phone calls were not answered.
6. From interviewing staff there appeared to be confusion about accurate waiting list figures and what actions were being taken to address these. Figures presented to the inspection team included 30,000 in June 2015 and 13,000 in September 2015.
7. The numbers by speciality of all patients within the non-RTT backlog and how these will be tracked going forward.

- The trust response addressed these points and assured the commission that action would be taken to:-
  - audit patients on the follow-up lists
  - strengthen the monitoring arrangements in place in relation to OPD follow-ups
  - strengthen arrangements for monitoring of short notice clinic cancellations
  - appoint a senior over-arching lead to drive the required improvements in OPD booking systems
  - Include call abandon rates as part of the key performance indicators to be monitored monthly
  - Provide waiting list information in a more ‘user friendly’ dashboard
- In June and August 2015, the executive team (ET) had acknowledged there was no national reporting or benchmarking available and there was no historical position about the OP backlogs known within the trust.

- The ET had agreed the focus on validation would remain within ophthalmology but that once complete the trust's data quality team would explore additional validation resources required to look at other OP specialty areas.
- Since 6 October 2015, the trust has been providing weekly progress reports on the validation of the OP waiting lists. These had shown sustained progress towards meeting the targets set.

Outpatients

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

- In 2014, an external company carried out an 'Out Patients Diagnostic Review' reviewed the systems and processes within the OPD, and looked at data between January and December 2014. Their findings showed:-
  - High levels of unused clinic slots, for example 13,000 in ophthalmology and 8,000 in urology
  - Local booking rules used in many specialties
  - High levels of overbooking or inflated templates to compensate for large did not attend rates
  - High administration costs (£197k) related to overbooking and cancellations
  - The top 13 specialties had a capacity opportunity of £15.2m
- The systemic problems with outpatients clinic bookings and cancellations meant the service:-
  - was unable to meet quality standards by NICE regarding frequency or reviews
  - received continued high numbers of complaints and incidents
  - had low staff morale
- For example, in April 2009 NICE issued guidelines on the diagnosis, monitoring and treatment of glaucoma. These guidelines recommend that certain areas of glaucoma-related work should be undertaken only by an optometrist with a specialist qualification or who is working under the supervision of a consultant ophthalmologist. The Royal College of Ophthalmologists together with the College of Optometrists published supplementary guidance on supervision in relation to glaucoma-related care by optometrists. Discussions had taken place between the CCG, the hospital and the local eye health network but compliance with these guidelines had not been achieved. The trust did not have any plans to demonstrate how it would achieve this.
- There were weekly meetings between the central data quality teams and the business groups to manage and monitor waiting lists and patient tracker lists (PTLs) and the executive team had oversight of the 18-week targets and outpatient follow-ups.
- We reviewed minutes from weekly clinic utilisation group between 17 September and 8 October 2015. We saw these minutes identified that clinic change forms were not being completed.
- The planned care manager told us they felt, "Processes (within OP bookings) had failed and collapsed." They said the situation had been the same for the past two years. They also said the processes used, such as bookings and patient tracker lists, "Used to be tight." When we asked them what they were going to do about it they said they would have more meetings with the OP nurse managers to look at clinic utilisation, did not attend rates and cancellations.
- They confirmed what staff had told us about not knowing which clinics were on, which doctors were coming and clinic change forms not being completed. They confirmed that this was not audited they said this would be monitored in the future.
- When we asked the OP nurse manager at the final (unannounced) inspection whether anything had changed since our first visit they said, "Nothing's changed since the last time you were here."

Pathology

- All of the on-site pathology departments were accredited with the clinical pathology accreditation. They were awaiting notification of their first inspection by the United Kingdom Accreditation Service. The Human Tissue Authority had inspected the mortuary by the in 2014; no issues were raised. This showed governance, risk management and quality measurement within pathology was good.

- The Path Links pathology general manager told us the service was working to meet all of the Key Performance Indicators of the Royal College of Pathologists.

Diagnostic Imaging

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

Leadership of service

Outpatients

- We found there were management responsibility and accountability structures in place within the outpatient's services.
- There was no matron for outpatients; there was no line manager between the band 7 OP nurse manager at each site and the planned care manager. The planned care manager was responsible for a large number of areas within the trust, across all three sites. These included cancer service, endoscopy, health records, outpatients and the nurse practitioners in immunology and transfusion.
- The OP nurse managers used a matron in one of the other services for clinical supervisions and clinical advice. This meant there was a lack of management support for the staff and managers working within the OPD.
- Staff we spoke with understood the departmental structure, and who their line manager was.
- The ophthalmology clinical lead said they felt there were, "Too many layers of management" to be effective.
- The trust submitted emails showing service managers had declined requests for time off from medical staff rostered for outpatient clinics were being declined. These included requests for annual leave and time off to carry out appraisals
- These were submitted to demonstrate that the trust was managing the clinics effectively. However, these emails showed several medical staff not happy with the system for approval of annual leave. One consultant wanted time off for Eid and had requested this several months previously and another had requested time off to complete appraisal with junior medical staff. This showed the problems with bookings and clinic capacities in the OPD were affecting the work life balance and professional responsibilities of medical staff working in the OP clinics.

Diagnostic Imaging

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

- Staff told us the radiologists were supportive of the local staff and gave good feedback to the radiographers. We interviewed the management team during the inspection. No significant issues were identified within radiology during the inspection. The managers were aware of the need to recruit more radiologists and this work was ongoing.
- Staff told us the executive team and non-executive team had visited the department recently and one staff member told us the visibility of the executive team had improved since our last visit.

Culture within the service

Outpatients

- Staff feedback about the culture within the OPD was mixed, mainly because of workload pressures and the ongoing clinical admin review for band 2 and band 3 staff. One medical secretary told us, "Morale has really been affected; the management are not looking after the staff."
- The planned care manager told us staff working in OP were, "Very tired, frustrated and fed up." They said they had a, "Good and open relationship" with the three OP nurse managers. When we asked them about communication they told us they had identified that there were, "Some blockages in sharing information with all staff groups."
- The OP nurse manager told us there were problems with communication about OP clinics from the service managers.
- Staff told us the OPD was, "nice to work for" and had "Good camaraderie" and "We're all there for each other." However, a senior nurse in the ophthalmology OP said it was, "Very frustrating"

Diagnostic Imaging

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

Public engagement

Outpatients

- We asked the planned care manager about feedback from the friends and family test (FFT), as we had seen in departmental minutes that these had been discontinued. They confirmed these meetings had been discontinued but were going to "be realigned to another meeting." They said there was no analysis of FFT comments received, "We just get a list of comments." They said these were shared at the governance meetings and, "Any negative comments are usually about the doctors."
- They confirmed the FFT results were 'a few months behind.' We asked what happened to the results of the FFT, they said they were fed through to the governance facilitator and they did not get any further feedback. They said the comments went back to the specialties involved, and not to the OPD.
- In the ophthalmology reception area we saw thank you cards and emails on display, these all gave positive feedback and the care and treatment patients had received in the department.

Diagnostic Imaging

- A patient survey had been carried out in plain X-ray and interventional radiology and 36 patients had responded.
- There was no other evidence of public engagement in radiology. This meant patient's view and experiences were not being gathered and acted on to shape and improve services.

Staff engagement

Outpatients

- The OP nurse manager told us they attended the monthly governance meetings and business meetings. The clinical support services unit produced an A3 'plan on a page' each month,
- One of the consultant staff in ophthalmology told us they got so much communication from the trust board that their email box was always full.
- Staff we spoke with were worried about the outcome of the clinical administration review. One clinic clerk said, "We've been having meetings, there are lots of changes. People are worried whether they will have a job."

Outpatients and diagnostic imaging

- Support staff said they did sometimes see senior managers in the departments, however one said, “No-one has introduced themselves.”
- On the final day of the visit, we asked two senior nursing staff and two support staff within the OPD whether there had been any changes made since our first visit. They all told us they were not aware of any changes.
- Staff nurse in ophthalmology told us they were planning an ‘ideas meeting for staff in ophthalmology, in addition to the regular monthly OPD meeting.

Diagnostic Imaging

- Staff feedback about the local line management support was extremely positive.
- Staff told us they knew how to contact the executive team and felt consulted about issues that affected them.
- Radiology held a team-briefing meeting once a month, which included a verbal synopsis of contents of trust-wide team brief. Trust and local issues, including incidents, were discussed.
- Radiographers told us they received positive mentoring by senior radiographers

Innovation, improvement and sustainability

Pathology

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

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. This must include but not be limited to: medical staff within ED and critical care, nursing staff within ED, medicine and surgery. It must also include a review of dedicated management time allocated to ward co-ordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service.
- The trust must ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need, ensure that the governance and monitoring of outpatients' appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment.
- The trust must ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to: staffing; critical care and ensuring the essential equipment is included in the trust replacement plan.
- The trust must ensure that staff at core service/ divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas.The trust must improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform.
- The trust must ensure it acts uponits own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development.
- The trust must ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas.
- The trust must ensure that all risks to the health and safety of patients with a mental health condition are removed in Scunthorpe emergency department. This must include the removal of all ligature risks, although must not be limited to the removal of such risks. The trust must undertake a risk assessment of the facilities, including the clinical room and trolley areas, but not be limited to those areas with advice from a suitably qualified mental health professional.
- The trust must ensure that the recently constructed treatment rooms at Scunthorpe that were previously used as doctors' offices are suitable for the treatment of patients on trolleys. This must include ensuring that such patients can be quickly taken out of the room in the event of an emergency.
- The trust must have a process in place to obtain and record consent from patients and/or their families for the use of the baby monitors in ITU.
- The hospital must ensure the safe storage of medicines within fridges. The trust must ensure staff check drug fridge temperatures daily and record minimum and maximum temperatures. Additionally it must ensure staff know that the correct fridge temperatures to preserve the safety and efficacy of drugs and what action they need to take if the temperature recording goes outside of this range.
- The trust must ensure equipment is checked, in date and fit for purpose including checking maternity resuscitation equipment and critical care equipment is reviewed and where required included in the trust replacement plan.

Outstanding practice and areas for improvement

- The trust must ensure there is an effectiveprocess for providing consistent feedback and learning from incidents.
- The trust must review the validation of mixed sex accommodation occurrences, to ensure patients are cared for in appropriate environment and report any breaches.
- The trust must ensure the reasons for do not attempt cardio respiratory resuscitation (DNACPR) decisions are recorded and in line with good practice within surgical services.
- The trust must ensure the five steps for safer surgery including the World Health Organisation Safety Checklist (WHO) is consistently applied and practice is audited in theatres.
- The trust mustreview the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre andthe number of on the day cancellations for patients awaiting operation.
- The trust must ensure policies and guidelines in use within clinical areas are compliant with NICE guidance or guidance from other similar bodies and that staff are aware of the updated policies, especially within maternity, ED and surgery.
- The trust must ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia. The trust must stop using newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty.

- The trust must ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours The trust must continue to improve against the target of all staff receiving an annual appraisal and supervision, especially in surgery, and that actions identified in the appraisals are acted upon.

Action the hospital SHOULD take to improve

- The trust should undertake work in a reasonable time-frame that will lead to the creation of separate waiting and treatment areas for children in the Scunthorpe ED that are safe and secure.
- The trust should undertake work in a reasonable time-frame that will lead to the creation of separate entrances in Scunthorpe ED for patients self-presenting with minor injuries or illnesses, and those conveyed by ambulance with serious injuries.
- The trust should review access and flow through the Scunthorpe angiography catheterization lab to reduce last minute cancellations, delays and wasted appointments.
- The trust should review patient flow through the Scunthorpe short stay ward to ensure this does not have an impact on the flow of patients through the clinical decisions unit.
- The trust should continue to improve against the target of all staff receiving an annual appraisal.
- The trust should as a matter of urgency address the continuing gap in clinical education in critical care.
- The trust should review patient flow and reduce the number of delayed discharges from ITU.
- The trust should introduce critical care specific morbidity and mortality meetings.
- The trust should continue to improve on its mandatory training targets to achieve its own compliance level of 95% and specifically ensure that staff have a better understanding of the assessment of capacity and the use of restraint (including chemical restraint).The trust should continue to work towards delivering care and treatment that is in line with national guidance and Core Standards for Intensive Care.
- The trust should ensure the lock on the intravenous fluids room in maternity at Scunthorpe hospital is in working order to ensure safe storage of the fluids.
- The trust should ensure all the maternity policies are up to date and reflect current guidance and that staff are aware of the up dated policies.
- The trust should review the use of pressure relieving equipment and preventative blood clot equipment within theatres.
- The trust should ensure the premises and location of the ophthalmology department is suitable for the purpose for which it is being used.

Outstanding practice and areas for improvement

- The trust should ensure there is sufficient space and seating for patients and their supporters in the outpatients departments.
- The trust should strengthen the support provided to nuclear medicine technologists by the ARSAC licence holder.
- The trust should ensure IR(ME)R training is mandatory for radiology staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: there were breaches of the national policy for mixed sex accommodation which compromised a person's right to privacy and dignity. Patients privacy and dignity was compromised by the use of baby monitors and CCTV on critical care and CCU at DPoW hospital. The trust must: • review the validation of mixed sex accommodation occurrences, to ensure patients are cared for in appropriate environment and report any breaches.Reg 10(1) • ensure that patients' privacy and dignity is maintained if the baby monitors and CCTV and in use.Reg 10(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: There was no review of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions post-operatively when the emergency situation may have changed or when patients were diagnosed medically fit, or transferred between hospitals. Consent was not been obtained/ recorded from patients and/or their families for the use of the baby monitors in critical care and for the use of CCTV in CCU at DPoWhospital. The trust must:

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:care was not always provided in a safe way as policies and guidelines were not all compliant with national guidance; there were risks to the health and safety of patients with a mental health condition at Scunthorpe emergency department; some clinical rooms at Scunthorpe ED were not suitable for the treatment of patients on trolleys: not all equipment was checked or where required included in the trust's replacement plan; fridge temperatures were not effectively monitored to preserve the safety and efficacy of drugs; there were not suitable arrangements in place in order to ensure the proper and safe management of medicines in people's homes.** The trust must: • ensure policies and guidelines in use within clinical areas are compliant with NICE guidance or guidance from other similar bodies and that staff are aware of the updated policies, especially within maternity, ED and surgery.Reg 12 (1) • ensure that all risks to the health and safety of patients with a mental health condition are removed in Scunthorpe emergency department. This must include the removal of all ligature risks, although must not be limited to the removal of such risks. The trust must undertake a risk assessment of the facilities, including the clinical room and trolley areas, but not be limited to those areas with advice from a suitably qualified mental health professional.Reg 12(2)(a), (b), (d) & (e)

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Requirement notices

- ensure that the recently constructed treatment rooms at Scunthorpe that were previously used as doctors' offices are suitable for the treatment of patients on trolleys. This must include ensuring that such patients can be quickly taken out of the room in the event of an emergency.Reg 12(2)(d)
- ensure equipment is checked, in date and fit for purpose including checking maternity resuscitation equipment and critical care equipment is reviewed and where required included in the trust replacement plan.Reg 12(2)(e) & (f)
- ensure the safe storage of medicines within fridges, specifically with regard to temperature and stock control.Reg 12(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met: systems and processes were not operated effectively to: assess, monitor and improve the quality and safety of services; assess, monitor and mitigate risks relating to the health and safety of patients; maintain some community records in line with recognised guidance and; seek and act on feedback from relevant persons.** The trust must: • ensure that staff at core service/divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas.Reg 17 (2)(a) • ensure the five steps for safer surgery including the World Health Organisation Safety Checklist (WHO) is consistently applied and practice is audited in theatres.Reg 17 (2)(a) • review the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre and the number of on the day cancellations for patients awaiting operation.Reg 17 (2)(a)

This section is primarily information for the provider

Requirement notices

- ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours.Reg 17(2)(a)
- ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need, ensure that the governance and monitoring of outpatients' appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment.Reg 17(2)(a)&(b)
- ensure it acts upon its own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development.Reg 17(2)(a)&(b)
- ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas.Reg 17(2)(a)&(b)
- ensure there is an effective process for providing consistent feedback and learning from incidents.Reg 17(2)(b)
- ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to: staffing; critical care and ensuring the essential equipment is included in the trust replacement plan.Reg 17(2)(b)
- improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform.Reg 17(2)(e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met: there were not always sufficient numbers of suitably skilled, qualified**

Requirement notices

and experienced staff deployedand not all staff received appropriate training, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform.

The trust must:

- ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. This must include but not be limited to: medical staff within ED and critical care, nursing staff within ED, medicine and surgery. It must also include a review of dedicated management time allocated to ward co-ordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service. The trust must stop including newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty.Reg 18(1)
- ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia.Reg 18(1)
- continue to improve against the target of all staff receiving an annual appraisal and supervision, especially in surgery, and that actions identified in the appraisals are acted upon. Reg18(2)(a)