Northern Lincolnshire and Goole NHS Foundation Trust

Evidence appendix

Diana Princess of Wales Hospital
Scar tho Road
Grimsby
Lincolnshire
DN33 2BA

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Date of inspection visit:
8 to 23 May 2018

Date of publication:
12 September 2018

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Acute hospital sites at the trust

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>Diana Princess of Wales Hospital, Scartho Road, Grimsby, DN33 2BA</td>
<td>Trauma unit at the emergency care centre (ECC), trauma and orthopaedics, level 3 intensive care, dedicated gynaecology ward including termination of pregnancy, neonatal unit</td>
<td>350,000 people across North and North East Lincolnshire and East Riding of Yorkshire.</td>
</tr>
<tr>
<td>Goole and District Hospital</td>
<td>Goole and District Hospital, Woodland Avenue, Goole, DN14 6RX</td>
<td>Trauma and orthopaedics</td>
<td>350,000 people across North and North East Lincolnshire and East Riding of Yorkshire.</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>Scunthorpe General Hospital, Church Lane, Scunthorpe, DN15 7BH</td>
<td>Trauma unit and hyper acute stroke services at the ECC, trauma and orthopaedics, level 3 intensive care,</td>
<td>350,000 people across North and North East Lincolnshire and</td>
</tr>
</tbody>
</table>
Community sites at the trust

The trust provides community services at 81 sites to a population of 350,000 people across North and North East Lincolnshire and East Riding of Yorkshire. Community services provided at these sites are listed below:

- Adult learning disability service
- Audiology
- Blue badge service
- Child health
- Chronic pain service
- Chronic wound service
- Community and therapy management
- Community dental service
- Community equipment service
- Community stroke service
- Continence service
- Core therapy service
- Dietetics
- Integrated occupational therapy
- Intermediate care service
- Macmillan health care/ palliative care team
- Maternity/midwifery services (including ultrasound)
- Paediatric therapies
- Physiotherapy
- Podiatry
- Psychology
- Rehabilitation
- Speech therapy
- Unscheduled care
- Urology
- Wheelchair services

Background to the trust

Northern Lincolnshire and Goole NHS Foundation Trust was established as a combined hospital Trust on 1 April 2001 and achieved Foundation Status on 1 May 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services trust (for North Lincolnshire).

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

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

(Source: *Routine Provider Information Request (RPIR) P2 – Sites)

The trust provides the following acute core services;
- Urgent and emergency care
- Medical care (including older people’s care)
- Surgery
- Critical care
- Maternity
- Children and young people
- End of life care
- Outpatients
- Diagnostics

The trust provides the following community core services in North Lincolnshire;
- Adults
- Dental
- End of life care

The trust’s management structure is based on six clinical divisions;
- Surgery and critical care
- Medicine
- Women and children’s
- Clinical support services
- Community and therapy services
- Path links

Each of the divisions is led by a triumvirate, which comprises of a clinical director, a head of nursing and a general manager.

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

The trust was placed in financial special measures in March 2017 and was placed back in to quality special measures in April 2017.

Services at this trust are commissioned by three clinical commissioning groups;
- North Lincolnshire Clinical Commissioning Group
- North East Lincolnshire Clinical Commissioning Group
- East Riding of Yorkshire Clinical Commissioning Group

The trust sits within the Humber Coast and Vale Sustainability and Transformation Plan (STP) footprint.

**Patient numbers**
From December 2016 to November 2017 there were:

- 419,070 outpatient attendances
- 97,804 inpatient admissions
- 33,611 planned elective surgical cases
- 149,813 attendances at the accident and emergency department
- 4,194 deliveries

(Source: Hospital Episodes Statistics December 2016 – November 2017)

Is this organisation well-led?

Leadership

The senior leadership team at the trust consisted of the chairman and chief executive, eight executive directors and six non-executive directors:

- Chairman
- Chief Executive
- Chief Operating Officer
- Medical Director
- Chief Nurse
- Director of Finance
- Director of Governance and Assurance and Trust Secretary
- Director of Strategy and Planning
- Director of Estates and Facilities
- Director of People and Organisational Effectiveness
- Six Non-Executive Directors

Since our previous inspection in November 2016 there had been changes to the membership of the board. The chief executive was appointed in August 2017; the chief operating office was in an interim role with a substantive appointment due to join the trust at the end of May 2018 and the medical director at the time of the inspection had been in an acting position since October 2017. This has resulted in a change of pace and impetus in terms of ensuring that these improvements continue and are sustained.

Of the executive board members at the trust, 0% were British Minority Ethnic (BME) and 58% were female.

Of the non-executive board members 0% were BME and 67% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0</td>
<td>58</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>All board members</td>
<td>0</td>
<td>62</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P64 Board Members - Diversity and list)
The board of directors’ portfolios covered all key areas. We found the trust executive leadership team had a range of skills and knowledge, for a number of members of the board it was their first director post. The chairman and chief executive acknowledged board development was required; however, the Chief Executive had not completed an appraisal or set objectives with all Directors. The trust informed CQC that appraisal dates had been set for August 2018. The trust had undergone an external board and governance review and was working with external agencies to facilitate board development sessions. At the time of the inspection the trust did not have a formal skills matrix for the board.

We did not see evidence that all executive and non-executive directors understood the scale of the trust’s challenges to finance, quality and sustainability. For example, we were given different figures and timescales for the trust’s financial recovery plan and the plan to manage the waiting list backlog. On review of the board papers and sub-committee meeting minutes we found limited evidence of challenge from some of the non-executive directors.

The trust had six clinical divisions; medicine, surgery and critical care, clinical support services, women and children’s, community and therapy services and Path links. The trust had undertaken a recent review of the governance and leadership in divisions to strengthen the clinical leadership in the organisation. From the beginning of May 2018 each division was led by a clinical director who was supported by a general manager and head of nursing. The executive team acknowledged there was a significant amount of work to do to establish accountability and effective clinical leadership throughout the organisation, but felt that clinical engagement in the trust was improving. The divisional leadership teams had development plans in place.

The Trust did not have a leadership or talent management strategy but had taken some actions to support leadership and talent management with a view to developing current leaders and leaders of the future and this would feed into the wider trust strategy. In 2018 the trust introduced apprenticeship leadership programmes to support succession planning and talent management. Information provided by the trust showed that 39 staff members were enrolled on a leadership apprenticeship programme. The trust was in the process of procuring a post graduate qualification in strategic management. A specific leadership course had been developed for ward managers and matrons to support the development of clinical leaders. In addition to the apprenticeship programme the trust delivered a team leaders essential course for succession planning and were developing an aspiring managers course for staff that did not meet the criteria for an apprenticeship.

Staff spoke positively about the new chief executive and many said that he had visited their wards and departments. The trust provided a schedule for chief executive visits to wards and departments, these included visits to clinical and non-clinical departments such as catering and was across all three hospital sites and also the pathology department based in Lincoln. Staff we spoke with in the core services described the chief nurse and heads of nursing as visible, approachable and supportive. Medical staff we spoke with were beginning to feel more involved in the delivery of clinical services and they felt this was down to the chief executive and acting medical director.

We carried out checks on site to determine whether appropriate steps had been taken to complete employment checks for executive and non-executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. We reviewed six director’s files (two non-executives and four executive) to determine whether the trust had taken appropriate steps to complete employment checks for executive staff in line with the FPPR. Directors completed annual self-declaration forms to confirm
that they complied with the regulation. These were all up to date in the six files we reviewed. We found that none of the directors had evidence within their personnel file that they had been subject to all the appropriate fit and proper person checks. Issues we identified included; a lack of photographic identification, no record of qualifications, no disclosure and barring service checks recorded and a lack of evidence of the recruitment process. Our findings at the inspection did not support the Fit and Proper Person’s Test: Chairman’s annual declaration dated October 2017 or that the processes and guidance in the trust’s Recruitment and Selection a Best Practice Guide (January 2016) had been followed. Given these findings, we were not assured that the trust was compliant with this regulation.

Vision and strategy

The trust had a vision, ‘working together we will deliver the highest quality, innovative, safe and compassionate healthcare services’ and values of ‘together we care, we respect, we deliver.’ In the core services we did not see that the vision and values were embedded despite there being visible displays throughout the trust of them. Staff we spoke with were not consistently able to explain what the vision and values meant to them.

It was clear that the trust had aspirations for the reconfiguration of services but staff we spoke with could not clearly articulate how this would be achieved. Some changes to service provision had already been made as a result of workforce limitations and fragile services but the full reconfiguration had not yet been collated and written into a strategy or plan.

Members of the board told us that following a review they felt the trust’s 2015 strategy was no longer fit for purpose. They described the trust’s current strategy as emerging and explained the board was working with the clinical divisions and system partners to develop this. The trust was also being supported by NHS Improvement and an external agency to create the strategy. The divisional teams were creating the detailed plans that would support the overarching strategy.

Although the trust did not have an overall strategy there were some supporting strategies in place for example; estates strategy, patient experience strategy and staff retention strategy. The trust had a learning disabilities and dementia strategy in place, both of these strategies had delivery plans in place which were overseen by the quality matron and quality and safety committee.

At the time of the inspection the trust did not have a nursing strategy. We were told this had been put on hold to allow meaningful engagement with staff and to work with partners to develop a shared strategy.

The trust did not have a mental health strategy although there were mental health policies in place. The deputy chief executive was the executive lead for mental health. At the time of the inspection, the Trust had a non-executive director lead for mental health, the Deputy Chief Executive and Director of Operations was previously the Executive Director lead. The operational lead is being reviewed following the appointment of the new Chief Operating Officer.

Sustainability and transformation plans (STP) are part of a national programme where the NHS, local authorities and social care form partnerships to improve health, the quality of social care and efficiency of services in a geographical ‘footprint’. The STP processes will inform part of the overall long-term strategy for the trust in terms of service configuration. Northern Lincolnshire and Goole
NHS Foundation Trust was part of the Humber, Coast and Vale STP; the STP footprint was over a large social geography and was less advanced than other STP’s nationally.

From our discussions during the inspection and with stakeholders the sustainability and transformation plan was less advanced than others. Further work was required within the local system and across the STP to develop a longer term strategy for service and financial sustainability. Since the arrival of the chief executive the trust had begun to actively engage with the STP and was committed to working with other trusts and partners to deliver sustainable patient care.

Culture

In September 2017 the national guardian’s office (NGO) carried out a review in relation to how staff were supported to speak out and raise concerns at the trust. This review had taken place in response to the number of whistle blowing alerts CQC and the number of contacts the NGO had received about the trust. The review identified learning for the trust and highlighted 23 specific concerns. The trust created an action plan in response to the report which was included within the trust’s Improving Together programme for organisational development and culture.

At our previous inspections and through our ongoing monitoring of the trust staff had spoken about difficult relationships with divisional managers and a fear of reprisal if they raised issues or concerns. At the time of this inspection the trust had a number of longstanding grievances that had not yet been resolved. Members of the executive team told us they felt that the trust had previously had an appetite to follow formal processes in these situations which had resulted in a number of grievances and disciplinary processes. Some changes had been introduced since our last inspection for example; the trust had invested in training staff in mediation using an external provider that specialised in the resolution of conflict. The Trust had introduced programmes to support ward and divisional managers and in June 2017 launched Listening into Action (LIA), a nationally recognised programme to support organisations to engage with their staff.

It was clear the leadership team recognised the culture in the organisation needed to change and there was evidence of initiatives underway with staff to change the culture. Staff we spoke with talked positively about the changes to the board and felt that the chairman and chief executive were committed to and leading a change in culture. The trust had introduced a pride and respect programme which supported a no tolerance approach to negative behaviours. One hundred and twenty staff had volunteered to become pride and respect champions. During the inspection we met with a number of the champions who were all positive about leading the change in culture in the organisation. The group was developing training for all staff and champions were being supported in undertaking mediator roles.

The trust had appointed a freedom to speak up guardian in January 2017. Freedom to speak up guardians operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team. We spoke with the trust’s guardian who told us that they were one of five candidates who applied for the role. The unsuccessful candidates had become associate guardians however; at the time of our inspection, only one associate remained in post. We were told that one of the reasons for this was due to there being no dedicated time allocated for the role, the trust had since been reviewed this and dedicated time was now available to the associates. The trust had placed an internal advert for further associates and received six expressions of interest. The guardian told us initially contact from staff was slow but since January 2018, the numbers of staff contacting the guardian had
increased. At the time of the inspection the guardian had 55 staff contacts, four of these wished to remain anonymous. The concerns raised by staff were predominantly related to staff behaviours, the processes following concerns raised about behaviours and patient safety. The freedom to speak up guardian prepared a report for the trust board and had benchmarked their activity with other organisations and shared learning and tools with the regional guardian. They also worked with a local NHS trust that had been successful in resolving cultural issues. The trust’s guardian told us working relationships with the executive team had improved since the appointment of the chief executive in August 2017.

Staff side representatives we spoke with told us they felt staff were more able to raise concerns without fear of reprisal. The freedom to speak up guardian held regular meeting with the joint negotiation and consultation committee (JNCC) and staff side representatives.

Staff had access to an occupational health service for staff, which provided counselling services, and access to help with physical health needs.

We found an improvement in staff recognising and reporting incidents and staff spoke of an open and honest culture in relation to patient safety. At this inspection we saw evidence that lessons were learned, acted upon, and shared across the trust in most divisions. The trust had a policy in place relating to the duty of candour and staff we spoke with were aware of their requirements in relation to this regulation.

The trust had a guardian for safe working. One of their main challenges was the reluctance from junior doctors to complete exception reports. Exception reporting is the formal mechanism that junior doctors on the new national contract should use to register variations from their agreed work schedule, in terms of their working hours and training. The guardian for safe working was working with the junior doctors and consultants at the trust to raise awareness and highlight the benefits of the reports. The guardian had submitted a proposal to the board to allow trust grade doctors to exception report. At the time of the inspection the board had not made a decision on this proposal.

**Staff Diversity**

The Trust produces an annual Equality & Diversity report which is submitted to the Trust Board.

**NHS Staff Survey 2017 – results better than average of acute trusts**

The trust had one key finding that exceeded the average compared to all acute trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF16. % working extra hours</td>
<td>71%</td>
<td>72%</td>
</tr>
</tbody>
</table>

**NHS Staff Survey 2017 – results worse than average of acute trusts**

The trust had 27 key findings worse than the average compared to all acute trusts in the 2017 NHS Staff Survey:
<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF12. Quality of appraisals</td>
<td>2.84</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>3.90</td>
<td>4.05</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>79%</td>
<td>85%</td>
</tr>
<tr>
<td>KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>34%</td>
<td>31%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.46</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.43</td>
<td>3.65</td>
</tr>
<tr>
<td>KF17. % feeling unwell due to work related stress in last 12 months</td>
<td>40%</td>
<td>36%</td>
</tr>
<tr>
<td>KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>58%</td>
<td>52%</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health and wellbeing</td>
<td>3.35</td>
<td>3.62</td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>40%</td>
<td>51%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.34</td>
<td>3.75</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.81</td>
<td>3.92</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>59%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.76</td>
<td>3.91</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.59</td>
<td>3.72</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.15</td>
<td>3.31</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.21</td>
<td>3.45</td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>20%</td>
<td>33%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.58</td>
<td>3.74</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.77</td>
<td>3.91</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>86%</td>
<td>90%</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.41</td>
<td>3.71</td>
</tr>
<tr>
<td>KF22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>16%</td>
<td>15%</td>
</tr>
</tbody>
</table>
KF23. % experiencing physical violence from staff in last 12 months  
3%  2%

KF24. % reporting most recent experience of violence  
63%  66%

KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months  
29%  28%

KF26. % experiencing harassment, bullying or abuse from staff in last 12 months  
28%  25%

Note – all of the key findings in the table above were in the worst 20% of trusts except for KF22, KF23, KF24, KF25 and KF26.

(Source: NHS Staff Survey 2017)

Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

There was no statistical difference between responses provided by BME staff and white staff in the four key questions above.

(Source: NHS Staff Survey 2017)
The trust had an equality action plan for 2017/18. The action plan linked to the trust’s equality strategy and objectives.

The trust had appointed an equality and diversity lead. All staff completed equality and diversity training, information provided by the trust showed that at the end of December 2017 overall compliance with this training was 93%. The trust had a new equality and diversity strategy in place that included equality objectives for 2018-2022.

At the time of the inspection staff morale was mixed; there were no staff networks in place, we were told there was a plan to develop these.

**Friends and Family test**

The friends and family test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

From February 2017 to January 2018 the trust scored above the England average for recommending the trust as a place to receive care. However, in the 12 month reporting period only 12.4% of eligible patients responded to the survey compared to the England average of 24.7%.

**Friends and family test performance, Northern Lincolnshire and Goole NHS Foundation Trust**

![Graph showing Friends and Family test performance](image)

(Source: NHS England)

**Sickness absence rates**

The Trust’s sickness absence levels from September 2016 to July 2017 were worse than the England average with the Trust’s trend over time reflecting the national trend. However, the Trust sickness rates were in line of their own internal target of 4.1%.
In the 2018 General Medical Council Training Scheme Survey the trust performed worse than expected for one indicator (educational supervision) and the same as expected for the remaining 17 indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance

Prior to the inspection the trust had reviewed its governance structures and processes as part of the work to improve clinical leadership and accountability in the organisation. At the time of the inspection some changes to governance were in progress and work was ongoing with the divisions to strengthen their governance framework.

Board assurance Framework

The board assurance framework (BAF) was the structure used by the board to identify the principal risks to the organisation in meeting its objectives. The trust had commissioned an external review of the BAF and corporate risk register and had made some changes to the documents and processes as a result of this review. The BAF identified the main risks across the organisation based on a range of information including governance reports, the risk register and performance data. The trust provided their board assurance framework, which detailed three strategic objectives within each and accompanying risks. A summary of these is below.
- Provide safe, compassionate care
- Staff feel valued and empowered
- Be a partner of choice

(Source: Trust Board Assurance Framework P113 W5 Board Assurance Framework, June 2017, October 2017, January 2018)

There was a committee structure in place to manage the board's business. There were five charitable fund committees: finance and performance; audit, risk and governance; quality and safety; health trees foundation trustees and renumeration. All sub-committees of the board were chaired by a NED and had clear terms of reference. There was also an executive management committee structure.

Specialities within divisions held monthly clinical governance meetings. These meetings reported to the divisional governance meetings.

We found some examples of where the board was not fully sighted on some of the risks in the organisation. For example, the trust did not have a central database of doctors that had restrictions on their practice. This was only identified during a serious incident investigation. At the time of the inspection a policy on doctors in difficulty/practising with restrictions was being written. This meant the board did not have oversight of the doctors working in the trust that were subject to restrictions on their practice. The board were also not aware of the deterioration in the time it took for patients suffering from fractured neck of femurs to go to theatre. We identified this as an issue at our two previous inspections and the audit results were worse at this inspection. The trust had developed action plans in response to the audit results but the actions had not had an impact on the performance outcomes. This did not give us assurance about the flow of information and escalation of risk from ‘ward to board.’

During our core service inspections, we observed effective and integrated working between the staff in the trust and the mental health provider. The trust received a quarterly report from the provider of mental health services. As the trust did not have an operational mental health lead we were unsure who reviewed this information and how the board gained assurance that people’s mental health needs were being met. Staff we spoke with about the management and oversight of the service level agreement between the trust and the mental health provider told us this was managed in the trust’s governance team.

Management of risk, issues and performance

Trust corporate risk register

The trust provided a document detailing their 21 highest profile risks. Each of these has a current risk score of 15 or higher. Details of the 10 risks with a current score of 20 or more are shown below:

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/12/2011</td>
<td>Failure to deliver required clinical improvements and reduce mortality ratio and potential for adverse patient impact.</td>
<td>25</td>
</tr>
<tr>
<td>01/06/2017</td>
<td>The trust could fail to deliver the quality measures outlined in the single oversight framework which consequently impacts on the provision of quality services and negatively impacts on the trust’s reputation with service users and regulatory bodies.</td>
<td>20</td>
</tr>
<tr>
<td>22/08/2016</td>
<td>Risk of exposure to legionella and other water based pathogens, adverse staff and patient impact and regulatory action.</td>
<td>20</td>
</tr>
<tr>
<td>14/11/2016</td>
<td>Insufficient backlog maintenance to meet regulatory and other requirements and address issues with an ageing estate.</td>
<td>20</td>
</tr>
<tr>
<td>24/11/2016</td>
<td>Lack of adequate controls to defend the trust’s computer systems when a cyber-attack occurs. Risk of further security breaches and risk of regulatory action.</td>
<td>20</td>
</tr>
<tr>
<td>27/07/2015</td>
<td>Failure to deliver financial improvement plan and risk of further regulatory action and intervention.</td>
<td>20</td>
</tr>
<tr>
<td>01/06/2017</td>
<td>Risk to delivering the required level of service.</td>
<td>20</td>
</tr>
<tr>
<td>29/12/2016</td>
<td>Risk to delivering the required level of service.</td>
<td>20</td>
</tr>
<tr>
<td>01/06/2017</td>
<td>There is a risk that organisational culture adversely affects the trust's ability to continuously focus on quality improvement adversely affecting patient care and the trust's reputation and relationship with regulatory bodies.</td>
<td>20</td>
</tr>
<tr>
<td>01/06/2017</td>
<td>Lack of clinical engagement - risk of failure to deliver the required service improvements.</td>
<td>20</td>
</tr>
</tbody>
</table>

(\textit{Source: Trust Board Assurance Framework P113 W5 Board Assurance Framework, June 2017, October 2017, January 2018})

The Board had worked with an external consultancy firm to develop the Trust’s risk appetite. This work completed in July 2017 and the Trust reviews its risk appetite annually, with the next review due on 28 August 2018. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current risk rating. Controls were identified to mitigate the level of risk and recorded with an action plan. There was evidence that the controls in place were reviewed and updated and that the risk rating was reviewed following the mitigating actions taken. The trust’s corporate risk register included risks that scored 15 and above.

The board were able to articulate some of key risks for the trust that included workforce, mortality, finance, culture and sustainability of services. However, we were not assured that the board had clear oversight and management of risk and performance, for example; the waiting list recovery plan and timescales for delivery were unclear despite intensive external support and the board did not articulate a consistent view of when the trust would achieve financial balance. Members of the
finance and performance committee were concerned about mortality and felt there was no evidence of learning from deaths on the mortality measures for the trust.

A number of the risks we identified at this inspection were ongoing issues that we had found at previous inspections, we spoke with the executive team about how the pace of change in the organisation was not at the rate we would have expected. For example, the trust had set up an internal clinical harm review group to ensure that all patients who were part of the trusts outpatient backlogs were clinically reviewed to ensure that they had not come to harm whilst on the waiting lists. In our October 2015 inspection we found a backlog of 30,667 patients. At our inspection in November 2016 there were further cohorts of patients discovered in unmonitored waiting lists which amounted to 18,000 patients and at this inspection the backlog of outpatient appointments had further deteriorated to 31,295 patients. The trust had been aware of waiting list backlogs since 2015 but internal clinical reviews did not commence until April 2017. At this inspection the trust could not provide assurance that patients from the October 2015 and November 2016 backlogs were not included in the 2018 backlog of appointments and thereby still waiting for appointments. At the time of the inspection there was no clear clinical validation or recovery plan for all specialities with trajectories to indicate when all patients who required follow up would have been seen.

The board received an integrated performance report which included metrics at trust-wide and divisional level. The trust acknowledged it was moving to a position of greater clarity and understanding of the quality of data and were taking actions to address weaknesses in it. Whilst data quality was improving there was work ahead to ensure good quality data across all services.

Following the appointment of an improvement director and clinical harm project lead work had begun to encourage ownership of performance in the divisions. The trust had developed an electronic system to support the clinical harm review which allowed the project lead and individual clinicians to track the progress of the harm reviews. Demand and capacity work and a recovery plan had been carried out in eight specialities; however, there were a further 10 specialities in which this work had not yet begun. The facilities team had created a performance dashboard which included both clinical and non-clinical measures, for example food service and environmental cleanliness. These dashboards were shared with all areas.

The chief nurse had introduced accreditation visits to every ward and a number of other clinical areas. The trust had been supported by their ‘buddy’ NHS trust with the implementation

**Finances Overview**

Information provided by NHS Improvement stated that the trust was formally in breach of its licence for both financial governance and quality. The trust had a financial improvement board (FIB) which had overall accountability for ensuring delivery of the financial improvement programme. The FIB provided an objective assessment of the status of projects in delivering the targeted outcomes, benefits and financial results and resolve barriers to delivery. The FIB reported to the board.

The trust did not have a financial strategy and the board could not articulate a consistent view of when the trust would achieve financial balance. NHS Improvement reported that the trust had introduced a number of financial grip and control measures, these had an impact on stabilising the run rate, however there had not been a significant improvement to the deficit monthly run rate.
### Financial metrics

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£333.94m</td>
<td>£344.90</td>
<td>£342.24m</td>
<td>£351.86m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(26.04m)</td>
<td>(£31.1m)</td>
<td>(£44.46m)</td>
<td>(£40.68m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£359.98</td>
<td>£375.32m</td>
<td>£386.70m</td>
<td>£392.54m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£359.24</td>
<td>£365.83m</td>
<td>£373.44m</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P69 Finances)

NHS Right Care is a national NHS England supported programme committed to delivering the best care to patients, making the NHS’s money go as far as possible and improving patient outcomes. This programme was being used in one speciality in the trust but the majority of services were behind other areas of the country.

The trust was identifying efficiency opportunities highlighted by Model Hospital and was working with NHS Improvements operational productivity team to develop 2018/19 cost improvement plans.

The trust presented financial information to NHS Improvement for monthly progress review meetings and regular financial special measures oversight meetings. In 2017/18, the trust commissioned an external review of activity coding, which demonstrated a number of issues resulting in an income shortfall for the trust. The trust was working on addressing these issues.

The trust had an £81.5 million backlog of estates and facilities maintenance. This was the fourth worst nationally. The facilities team had created a separate compliance team to ensure that they were meeting the regulatory requirements. In addition to this, they had also commissioned an external audit that had been reported as giving significant assurance.

### Information management

The board received a vast amount of information, there was an acknowledgement by the board that their focus should be on delivery and outcomes and work needed to be done to provide information to support that.

Members of some of the sub-committees we spoke with said they had previously lacked confidence in the figures and information they were presented with, for example, the waiting list backlog. They engaged with clinical teams to encourage ownership and felt they now had confidence in the figures and the recovery plan.

The trust had an electronic information system that developed, deployed and supported clinical software applications across primary, secondary and intermediate care. The system provided innovative software designed by clinicians that released time to allow them to deliver quality patient care.

There were arrangements to ensure the availability and integrity of identifiable data, records and data management systems in line with data security standards. The trust supported these
arrangements and policies with training so staff knew how to manage information correctly. However, during our inspection in 2016 we found patient records were not stored securely in some outpatient clinics which meant that patients’ personal information may not always be protected appropriately. This was an ongoing concern at this inspection.

The trust had effective arrangements to ensure that data or notifications were submitted to external bodies as required. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system (NRLS) or the NHS strategic executive information system. Prior to our inspection we had noticed delays in the trust uploading information to the NRLS system; this had been due to changes in the trust’s systems and processes and also changes to the national incident codes.

Engagement

The executive team were working to improve staff and stakeholder engagement recognising that some relationships had been challenging in the past. Following the trust being placed in quality special measures in April 2017 a system improvement board was established led by NHS Improvement which supported the trust to work effectively with partners. Prior to the inspection we received feedback from the trust’s partners about how the relationships were improving and collaboration between partners and working across boundaries was beginning.

The trust participated in national patient surveys, for example the friends and family test, CQC inpatient survey. The trust board was presented each month with a patient-related story. The trust had run public engagement sessions in Grimsby, Scunthorpe and Goole on a number of occasions in the 12 months prior to inspection. These sessions included discussions about challenges, good news stories and service developments. The trust used social media to communicate with and involve the public.

The trust had some systems in place to ensure the voice of patients was heard. There were dementia specialist nurses and a learning disability specialist nurse in post. One of the quality matrons was working with the Royal College of Nursing on initiatives to support vulnerable patients. The trust used ‘John’s campaign’ to help encourage the carers of patients living with dementia to become involved in their loved ones care.

The chief nurse had become responsible for the oversight and management of the patient experience and complaints teams and we understood that patients would be involved in creating a new joint strategy for complaints and patient experience.

Quarterly forums were in place to support junior doctors. These were held on both acute hospital sites with video conferencing across site. It was acknowledged that due to high medical vacancies and locum use, junior doctors did not always feel that they were sufficiently supported at the trust. This deanery had withdrawn junior doctors from cardiology services at the trust in 2017 for this reason. The trust was aware of the need to identify good educational supervisors for junior doctors to mitigate the risk of junior doctors being withdrawn from the trust permanently.

The trust had a focus on vacancy and recruitment management. Exit interviews were collated when staff left the trust; however, the response rate varied between 3% and 30% and to date no themes or trends had been identified.
In the staff survey results 2017, the trust scored lowest in the country in its response to the question on whether or not staff would recommend working at the trust.

Staff we spoke with told us about the trust’s annual staff awards ceremony ‘our stars.’ They were positive about the award schemes and said they helped to make staff feel valued.

The trust facilities team had worked with the criminal prosecution service and police to create a joint working agreement on tackling violent and aggressive behaviour. This document had been presented in the House of Commons.

Learning, continuous improvement and innovation

There was a shift to focus on learning and improvement in the organisation. As a result of being placed in quality special measures in April 2017 the trust received an extensive support package led and coordinated by NHS Improvement which included being partnered with a ‘buddy’ NHS trust. As well as this the trust commissioned a high number of external reviews and we had some concerns about the ability of staff at all levels in the organisation to recognise where and when improvements were required in their own services.

The trust had appointed a substantive central improvement team incorporating 14 whole time equivalent staff to support the delivery of the Improving Together programme, which was addressing both quality and financial special measures. Improving Together includes five work streams: quality and safety, access and flow, organisational development and culture, service strategy and finance. Each work stream had an executive lead and an oversight group which reported to the trust’s Improving Together board.

The trust had a lead quality improvement trainer and had successfully secured funding to support a six month secondment for a quality improvement practitioner as a dedicated resource to support the training, development and implementation of the quality improvement vision the trust had.

We reviewed seven serious incident investigations which had evidence of appropriate investigations, focused on learning and were led by an appropriate member of staff. The involvement of the patient, family and carers in the investigation varied. There were action plans in place for each of the incidents with accountable persons; however, some of the timescales set to achieve the actions were lengthy. Staff in the governance team were reviewing the process for investigating serious incidents and introducing more human factors, live drills and simulation to support learning and embed actions in clinical practice. During our inspection we saw that learning was shared after incidents had been reported in most core services.

The trust had developed an apprentice scheme which had won awards from Health Education England and a local college to support klearning and development of staff in the workplace.

The trust had not fully responded to the 2017 NHS National Quality Board guidance on Learning from Deaths and the 2016 CQC report ‘Learning, candour and accountability’. At the time of the inspection the mortality improvement group had only been in place for a couple of months and their priority was to refresh the strategy and focus on clinical engagement. The clinical harm review group identified that 181 patients in the outpatient backlog had died whilst waiting for a follow-up appointment. The trust had not completed a formal review of these patients to see whether the delay in appointments or treatment may have contributed to the patient death. Following the inspection,
we raised concerns about this and the trust put actions in place address this. The trust was using the Royal College of Physicians tool to review some deaths in the organisation in a structured way.

**Complaints process overview**

The complaints manager acknowledged that complaints responses were not met in line with trust policy. This was attributed to a lack of ownership within the divisions, a lack of engagement by clinical teams and an over reliance on email use for communication.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for acknowledging complaints?</td>
<td>3 working days</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30 working days</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>45 working days</td>
<td>41%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>60 working days</td>
<td>33%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process from February 2017 to February 2018</td>
<td>2,092</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P61 Complaints)

**Number of complaints made to the trust**

The trust received 480 complaints from February 2017 to February 2018. A breakdown of complaints by core service is shown below:

**Trust level**

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>% of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>115</td>
<td>24%</td>
</tr>
<tr>
<td>Surgery</td>
<td>131</td>
<td>27.3%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>99</td>
<td>20.6%</td>
</tr>
<tr>
<td>Outpatients and diagnostics</td>
<td>50</td>
<td>10.4%</td>
</tr>
<tr>
<td>Maternity</td>
<td>19</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>2.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>13</td>
<td>2.7%</td>
</tr>
<tr>
<td>Community adults</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Critical care</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>9</td>
<td>1.8%</td>
</tr>
<tr>
<td>CHS - Children, Young People and Families</td>
<td>3</td>
<td>0.6%</td>
</tr>
<tr>
<td>CHS - Community Inpatients</td>
<td>3</td>
<td>0.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>2</td>
<td>0.4%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>1</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
At trust level, the majority of complaints were about surgery with 131 complaints (27.3% of complaints), medical care with 115 complaints (24%) and urgent and emergency care with 99 complaints (20.6%). The same core services had the highest number of complaints at each of the three acute hospitals.

There were 19 complaints regarding community services. The majority of complaints for community services were about community health services for adults with ten complaints (52.6% of all community complaints).

(Source: Routine Provider Information Request (RPIR) – P61 Complaints)

Compliments

From February 2017 to January 2018, the trust received a total of 277 compliments. A breakdown by core service is shown below:

Trust level

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of compliments</th>
<th>% of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and emergency services</td>
<td>77</td>
<td>27.8%</td>
</tr>
<tr>
<td>Surgery</td>
<td>59</td>
<td>21.3%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>35</td>
<td>12.6%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>30</td>
<td>10.8%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>30</td>
<td>10.8%</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>5.8%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>14</td>
<td>5.1%</td>
</tr>
<tr>
<td>Maternity</td>
<td>5</td>
<td>1.8%</td>
</tr>
<tr>
<td>Adults Community</td>
<td>5</td>
<td>1.8%</td>
</tr>
<tr>
<td>Critical care</td>
<td>3</td>
<td>1.1%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>3</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

At site level, 54.5% of all compliments (151) were about Diana, Princess of Wales Hospital, 115 (41.5%) were about Scunthorpe General Hospital and there were eight compliments about Goole and District Hospital (2.9%).

The services with the most compliments at the trust were urgent and emergency care with 77 compliments (27.8% of all compliments) and surgery with 59 compliments (21.3% of compliments).

There were five compliments for community services, all of which related to community adults services.

(Source: Routine Provider Information Request (RPIR) – P61 Compliments)

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.
The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pathology Accreditation (CPA) and its successor</td>
<td>Full CPA accreditation awarded May and October 2014 for Path Links NHS Pathology sites for all disciplines</td>
</tr>
<tr>
<td>Medical Laboratories ISO 15189</td>
<td>UKAS ISO 15189 transition visit undertaken October 2017 with evidence submission completed February 2017 for findings raised. CPA accreditation remains in situ until transition to ISO is confirmed.</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

The trust was focusing on workforce planning alternatives models of care were being implemented. This included the recruitment advanced care practitioners (ACP’s) and also training existing staff to become ACP’s.

The trust offered four tiers of parking to staff and that they have been awarded the ‘Professionalism in Parking Accreditation (PIPA).

We were given some examples of outstanding practice from the learning disabilities team. This had involved a multi-disciplinary approach to reducing patients anxiety and supporting them emotionally and physically to achieve the best possible outcomes when they needed to be admitted to hospital including both outpatient and inpatient examples. The team were inviting patients with learning disabilities to visit the trust during the national learning disabilities awareness week. This would include showing patients around areas of the hospital and identifying equipment so that if they were admitted as patients they would have some prior knowledge and experience to make them less anxious about their admission.

The trust had developed, deployed and supported an electronic clinical software applications system across primary, secondary and intermediate care. The system provided innovative software designed by clinicians that released time to allow them to deliver quality patient care.

The trust had developed an electronic system to support the clinical harm review which allowed the project lead and individual clinicians to track the progress of the harm reviews. The trust had showcased this system at the NHS Improvement Conference in April 2018.
Scunthorpe General Hospital - Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services.

- Diana, Princess of Wales Hospital.
- Scunthorpe General Hospital.

Minor injuries unit at Goole Hospital provided services up to April 2018 when the provider changed.

(Source: Trust Routine Provider Information Request)

Activity and patient throughput.

Total number of urgent and emergency care attendances at Northern Lincolnshire and Goole NHS Foundation Trust compared to all acute trusts in England.

There were 151,765 attendances from April 2016 to March 2017 at Northern Lincolnshire and Goole NHS Foundation Trust as indicated in the chart above.

(Source: NHS England)
Urgent and Emergency Care attendances resulting in an admission.

The percentage of A&E attendances at this trust that resulted in an admission remained similar from 2015/16 to 2016/17 and was slightly lower than the England average. 
(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>32,094</td>
</tr>
<tr>
<td>Discharged*</td>
<td>87,781</td>
</tr>
<tr>
<td>Referred*</td>
<td>21,143</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>4,128</td>
</tr>
<tr>
<td>Died in department</td>
<td>165</td>
</tr>
<tr>
<td>Left department#</td>
<td>4,497</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP.
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional.
# Left department includes: left before treatment or having refused treatment.
(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

At our last inspection in November 2016 the completion rate was 76% which was below the trust target of 85%. We also found that there was no record of attendance for training sessions. At this inspection, staff informed us that mandatory training compliance in March 2018 was 70% for nursing staff and plans were in place to be 95% by January 2019. We saw evidence of training
files stored in the department. We were told there was a link training nurse who monitors staff compliance.

Staff accessed online training and received an automatic email when training was due. We were told by ward managers that staff were allocated time on the off-duty rota to complete training whilst on duty. We spoke with three staff members, who all commented that there was not enough time to complete online training during their shift. They felt that there was an expectation to complete it in their own time.

We requested information from the trust regarding training specifically for children. The trust sent us mandatory training figures for safeguarding children level one, two and three. In addition, they told us that 33 staff on the department had completed paediatric intermediate life support, meaning 62% of registered nurses had completed the course. Further training for resuscitation identified that five staff had completed a two-day European Paediatric Life Support (EPLS) course which was valid for four years.

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses from February 2017 to January 2018 for medical staff by site is shown below:

**Scunthorpe General Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of medical staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>9</td>
<td>17</td>
<td>52.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>9</td>
<td>17</td>
<td>52.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>8</td>
<td>17</td>
<td>47.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – Object</td>
<td>7</td>
<td>17</td>
<td>41.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>6</td>
<td>17</td>
<td>35.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>6</td>
<td>17</td>
<td>35.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>4</td>
<td>17</td>
<td>23.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>4</td>
<td>17</td>
<td>23.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>4</td>
<td>17</td>
<td>23.5%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for medical staff in urgent and emergency care was 45.0% at trust level and 42.4% at Scunthorpe General Hospital. This was below the trust target of 85%.

At site level, the trust target was not met in any mandatory training module except for resuscitation at Scunthorpe General Hospital.

A breakdown of compliance for mandatory courses February 2017 to January 2018 for qualified nursing staff by site is shown below:

**Scunthorpe General Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of nursing staff</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Manual Handling – Object | trained (YTD) | 46 | 53 | 86.8% | 85% | Yes
---|---|---|---|---|---|---
PREVENT Level 1 | 44 | 53 | 83.0% | 85% | No
Equality and Diversity | 44 | 53 | 83.0% | 85% | No
Infection Control - 1 Year | 41 | 53 | 77.4% | 85% | No
Slips, Trips & Falls | 40 | 53 | 75.5% | 85% | No
Fire Safety 2 years | 38 | 53 | 71.7% | 85% | No
Resuscitation | 37 | 52 | 71.2% | 85% | No
Information Governance | 35 | 53 | 66.0% | 85% | No
Conflict Resolution | 31 | 53 | 58.5% | 85% | No
Manual Handling – People | 25 | 52 | 48.1% | 85% | No

The overall mandatory training completion rate for nursing staff in urgent and emergency care was 72.4% at trust level and 72.2% at Scunthorpe General Hospital. This was below the trust target of 85%.

At site level, the trust target was met in one out of ten modules at Scunthorpe General Hospital.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Safeguarding

At our last inspection in November 2016, we were not assured that safeguarding assessments had taken place in the emergency department. During this inspection, staff were aware of how to report safeguarding. Policies and procedures were in place for staff to follow. Safeguarding information and pathways were on display around the department for both patients and staff to view. We saw that staff responded appropriately to patients with safeguarding concerns. Staff provided us with examples of when they had referred to safeguarding to ensure patients were safe.

Staff told us that the streaming nurses were trained in safeguarding level three and showed awareness of the safeguarding process. Staff told us that they reported safeguarding concerns and could explain the process was easy to follow. Staff told us that feedback from safeguarding referrals was not common. We observed staff accessing the safeguarding referral form on the trust intranet.

Safeguarding information was highlighted on both adult and children assessment documentation that was required to be completed by staff. The department completed a dashboard monthly; this included auditing records to identify if safeguarding information was completed. We reviewed the audits from January to May 2018 and found that records indicated the majority of patients did not present with any safeguarding risk factors or concerns. In April 2018, the audit identified that out of 144 records, 11 patients presented with a safeguarding concern. The audit identified that only four out of the eleven records had a safeguarding referral which had been completed.

We looked at 47 records to review if safeguarding concerns had been recorded. We found this information was documented in 41 records. In six records it was not documented if there were safeguarding concerns, which meant we were not assured that safe measures were in place. One record identified there was a safeguarding concern, this had been completed appropriately and a referral completed.
The Multi Agency Risk Assessment Conference (MARAC) was a referral form for staff to complete for patients that could be suffering from domestic abuse. Staff showed a good understanding of MARAC referral process and how to access the form on the trust’s intranet.

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses February 2017 to January 2018 for medical staff by site is shown below:

### Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of the course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>15</td>
<td>17</td>
<td>88.2%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>11</td>
<td>17</td>
<td>64.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>7</td>
<td>11</td>
<td>63.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for medical staff in urgent and emergency care was 76.1% at trust level and 77.4% at Scunthorpe General Hospital. This was below the trust target of 85%.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for nursing staff by site is shown below:

### Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of the course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>41</td>
<td>53</td>
<td>77.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>40</td>
<td>53</td>
<td>75.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>40</td>
<td>53</td>
<td>75.5%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>19</td>
<td>39</td>
<td>48.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for nursing staff in urgent and emergency care was 77.6% at trust level and 70.7% at Scunthorpe General Hospital. This was below the trust target of 85%.

### Cleanliness, infection control and hygiene

At our last inspection in November 2016, we were not assured that systems were in place for infection prevention and control. The department now had dedicated staff and increased domestic support to ensure that compliance with infection control measures were met. At this inspection we saw that there had been an improvement and systems were in place. All the cubicles we checked had cleaning checklists which had been completed daily. We checked eight mattresses and found a tear in one. This was reported to the matron who assured us that this would be actioned. Mattresses were checked after each patient use and by the estate department every six months.

We saw that the department including the waiting area and nursing station was visibly clean, with no apparent dust and there was cleaning in progress during our inspection. We checked the dirty...
utility room which was clean with bags tied appropriately. Throughout the department we saw ‘I am clean labels’ in date and signed. We observed the trolleys on the unit to have cleaning checklists and were cleaned daily. We checked various sharp bins, none of which were over filled. All the sharp bins were dated and signed appropriately. In the children’s waiting area, the toilets were clean and had a call bell and changing facilities.

Personal protective equipment (PPE) was available throughout the department for staff to use. We observed that alcohol hand gels were available at each cubicle space. We observed staff to be bare below the elbows, adhering to the uniform policy and using the correct handwashing technique. Patients told us they had observed staff washing their hands.

We spoke with staff whose main role was to assist with the hygiene and cleanliness of the department. They spoke of the importance of infection control and how they contributed to patient safety by ensuring that they followed the trust’s infection control policy. Staff also told us the estates team would email the department three times per week to prompt the shift lead to flush the showers; this was to prevent such infections as legionella.

In the department there was a specific room designed to enable isolation of patients with an infectious condition. The room did not have a separate adjoining toilet for patients that needed to be isolated. However, staff explained a separate commode would be used for those patients and cleaned appropriately.

We observed that mops with different coloured buckets available in the department and stored correctly. This ensured that infection prevention controls were adhered to. Chemicals used for cleaning had appropriate instructions for storage and usage.

Environment and equipment

The waiting areas had been improved since the last inspection. Building work was underway, at our inspection in November 2016, to change the waiting area at the front of the department and create a separate children’s waiting area. The changes had now been completed. The waiting area had been revamped and the chairs were facing reception and patients were visible to staff at the front desk. The department used the NHS initiative ‘fit to sit’ which encouraged patients that were well enough to sit rather than lie on trolleys waiting to be seen. The children’s waiting area contained a seating area, television and children’s toys. The area was secured with a small stable style gate which had security measures to stop hands coming trapped. We saw the area was used frequently during our inspection.

The department was separated into different areas for patients to be reviewed. These included minors, majors and resuscitation areas where patients could be seen dependant on their needs. The resuscitation area had three cubicles; one of these was fully equipped with all sizes of equipment for paediatric and neonatal patients.

Within majors there were 15 cubicles for patients. The department also had a designated mental health room which was in sight of the nurse’s station. We inspected the room and found that it did not contain any ligature risks.

There was a dedicated ambulance entrance with an overflow area for ambulance crews awaiting handover. There were five bays in the nurse led-rapid assessment area for patients who arrived by ambulance which could be visualised from the nurse’s desk. Patients had an initial rapid assessment by a nurse before they are streamed to various areas of the department.

At our inspection in November 2016, we had concerns about the security in some areas of the department. This included access to high risk areas in the department such as resuscitation areas.
At this inspection a lockdown system had been introduced which restricted access through certain corridors. There was also a security office next to the waiting room.

We checked different types of equipment in the department. All the equipment was in good working order and had received portable appliance testing (PAT) to identify that it had been checked. The equipment had a label to identify when it had the PAT test completed.

Resuscitation trolleys, including paediatric and neonatal, were available in the department and labelled with an equipment list. We checked all the trolleys and found that they all contained the relevant equipment. Checklists were in place for staff to monitor and check that they had completed a review of the daily checks. We saw evidence that these daily checks had taken place. This had improved since our last inspection.

**Assessing and responding to patient risk**

The trust used a National Early Warning Score (NEWS) to measure whether a patient’s condition was improving, stable or deteriorating; this indicated when a patient may require a higher level of care. At our inspection in November 2016, we found that NEWS were not always recorded and no paediatric early warning scores (PEWS) were documented.

At this inspection, an electronic NEWS score was in place and this linked to the patient’s electronic record. The NEWS score would be highlighted on the screen and indicated when the next observations were due to be completed. We saw that when a patient’s observations were due this flashed on the screen to alert staff who would then review and completed the NEWS. The electronic system showed whether the NEWS score had increased, decreased or stayed the same. The PEWS scoring had recently changed into separate age ranges to ensure that the physiological parameters within the various ages reflected the correct range. These forms were not accessible electronically but paper copies were available.

The department completed a dashboard monthly; this included auditing records to identify if early warning scores were recorded. We reviewed the dashboard from January 2018 to May 2018 which identified that the majority of records had NEWS scores completed and the score had been actioned with an appropriate clinical response. According to the April 2018 audit, 100% of patients had an early warning score completed; 99.3% of which had the appropriate clinical response follow up. The remaining percentage had been classified as not requiring an appropriate clinical response.

We reviewed 42 records where NEWS and PEWS should have been recorded. We found that 33 records contained the relevant information and nine records did not. This had improved since our last inspection in November 2016 however further compliance was required.

The monthly dashboard also reviewed whether the sepsis assessments were completed. The sepsis screening tool was expected to be completed when the NEWS score was above five or there was a single parameter of three or above. We reviewed the dashboard from January 2018 to May 2018 which identified that the scores for 30 patients had triggered a sepsis assessment. Out of the 30 it identified that 27 had a screening tool completed.

**Median time from arrival to initial assessment**

The median time from arrival to initial assessment was consistently worse than the overall England median from February 2017 to January 2018.

An improvement in the trust’s performance was seen in October 2017 with a continued lower performance for the remaining reporting period. In the most recent period (January 2018) the trust reported a median initial time to assessment of 15 minutes compared to the England median of nine minutes.
Ambulance – Time to initial assessment from February 2017 and January 2018 at Northern Lincolnshire and Goole NHS Foundation Trust.

A streaming and triage process was in place where a registered nurse sat at the reception desk and streamed patients to the most appropriate place. The streaming nurse could refer patients to be seen more appropriately by the GP primary care service on site or directly into the majors department to be triaged and observations taken by the appropriate nurse. Patients were triaged using a recognised triage tool and could also be referred to the minors area of the department to be reviewed by an emergency care practitioner.

Patients arriving by ambulance were brought into a separate area which contained spaces for up to five patients and triaged by a registered nurse allocated to the area. We interviewed four patients who arrived by ambulance all reported they had been seen straight away.

We witnessed 12 patients arriving by ambulance and being booked in, 42% were handed over to emergency department (ED) within five minutes and 84% were handed over within 15 minutes. We looked at 23 retrospective patient notes, the average time to initial assessment was 26 minutes and 35% of patients were seen in less than 15 minutes and 96% were seen in less than one hour.

**Percentage of ambulance journeys with turnaround times over 30 minutes**
From March 2017 to February 2018 the percentage of ambulance journeys with turnaround times over 30 minutes at Scunthorpe General Hospital was generally similar over time. There was an improvement reported from October 2017 to December 2017 with the lowest percentage of 57% reported in December 2017.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Scunthorpe General Hospital.**

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Scunthorpe General Hospital.**
We spoke with several paramedics who attended the department regularly; they confirmed that the turnaround time had changed and improved since our inspection. At that inspection patients were handed over to ED staff and then booked into the hospital at reception. If the crew had to wait more than 15 minutes, patients would be booked in after that time which would affect the waiting time as it was not recorded. At this inspection the system had changed, patients were booked straight into ED by an electronic system on arrival to the department. This meant that the figures were a true reflection of the time they arrived and stayed within the department.

The department had a designated mental health assessment room which was in sight of the nurse’s station. This room was ligature free. The mental health assessment room had guidance on the door for staff on the steps they should take if a patient with mental health concerns required the room. This included completion of a mental health risk assessment and the removal of the equipment in the room. The department had identified a member of staff to be a mental health champion.

A mental health risk assessment was incorporated into a standard operating procedure (SOP) for the management of patients with mental health presentations within the emergency department. It contained a flow chart, risk assessment and a threshold assessment grid (TAG) which provided an overall TAG scoring for the patient. Staff would record in the SOP and gather information to formulate a risk score. The TAG score provided a clear indicator of the patient’s risks and the actions staff should take depending on the score. For example, if the patient was identified as a medium risk, 30-minute face to face observations should be completed and the patient should receive treatment in an identified assessment room or high visibility cubicle. However, the SOP did not allow for staff to write a detailed update of ongoing issues whilst in the department and actions taken for each level of risk. The information would be documented in the routine ED patient record. Within the SOP it allowed staff to reassess the level of risk and note any changes to the risk level.

There were three patients presenting with mental health issues in the emergency department at the time of our inspection, two adults and one child (aged 17). All three had scored either medium or high on the TAG score sheet. However, during our inspection we observed a patient, who had been assessed as high risk in the mental health room with the door closed. They were alone and had a phone charger which posed a potential ligature risk.

Staff in the department used the mental health risk assessment SOP and could tell us how they would manage patients in the department with mental health needs. We reviewed the documents for the three patients in the department with mental health needs and found the relevant information had been completed. The department completed a monthly dashboard. This included auditing records to identify if mental health information was completed. For March and May 2018, it identified that 13 patient records were reviewed of patients that had attended the department with a mental health need. Eleven patients had a mental risk assessment completed and were managed in the appropriate environment.
There was no separate paediatric clinical area. Children would be seen in the relevant clinical area dependant on their needs. Some cubicles had been made into a child friendly environment. However, they were surrounded by cubicles where adult patients were receiving their care. A resuscitation bay for children was appropriately equipped for patients that required that level of care. Between April 2017 and March 2018 there had been 11,764 paediatric attendances at the department. A paediatric support pathway was in place, this was displayed around the department and staff knew who to contact. The pathway identified the process to follow for paediatrics for both major and minor injuries presenting at the department.

Staff reported that the department had a good relationship with the paediatric team and that they would accept direct referrals if the emergency department is busy. Staff felt that they were responsive and worked well together.

The staff told us that they could access a specialist stroke responder from the stroke unit when needed. A stroke responder would come to the department to ensure patients who had a stroke received evidence-based treatment in a timely manner.

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 5. Once you arrived at the hospital, how long did you wait with the</td>
<td>8.5</td>
<td>About the same as</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.4</td>
<td>About the same as</td>
</tr>
<tr>
<td></td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q 9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.6</td>
<td>About the same as</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>before being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as</td>
</tr>
<tr>
<td></td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q 34. While you were in the emergency department, did you feel</td>
<td>9.6</td>
<td>About the same as</td>
</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td>other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From February 2017 to January 2018 the trust reported 1,084 black breaches at Scunthorpe General Hospital.

There was a reduction in black breaches over time at Scunthorpe General Hospital, with the highest numbers of black breaches reported from February 2017 to April 2017 (an average of 164 per month). Although the number of black breaches generally reduced from August 2017, a higher number was reported in January 2018 (112 breaches).
Nurse staffing

The trust reported their registered nursing and midwifery staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>151.6</td>
<td>154.6</td>
<td>157.7</td>
<td>143.8</td>
</tr>
</tbody>
</table>

The trust had a 1.7% over-establishment for nursing staff in urgent and emergency care in January 2018 with all sites reporting more nursing staff in place than were planned. For the previous year (January 2017) the trust had a nursing staff fill rate of 92.7%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Annual vacancy rates for nursing staff in urgent emergency care from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE as at January 2018)</th>
<th>Total number of staff establishment (WTE as at January 2018)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>-3.0</td>
<td>151.6</td>
<td>21.5%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 16.3% for nursing staff in urgent and emergency care, which was above the trust’s target vacancy rate of 6.3%. This did not meet the trust’s target for vacancy rate.
Please note, while the figures for January 2018 show an over-establishment at all sites, the annual rate is calculated over the 12-month reporting period.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

At the time of our inspection there were four vacancies for band five registered nurses. The number of band two staff (carers) had been increased to provide personal care and care rounds to patients ensuring that their basic needs had been met.

Paediatric nurse staffing had reduced since our last inspection in November 2016. Previously there had been one registered sick children’s nurses (RSCN) within the department. At the time of inspection there were no RSCNs. This meant that the Intercollegiate Emergency Standard to have sufficient RSCNs to provide one per shift was not met. No registered nurses or ENPs had completed any further university modules specifically focusing on paediatrics.

The department had determined what number of nursing staff was required on each shift to maintain safety of patients. Planned staffing for the dayshift was nine registered nurses, two emergency nurse practitioners (ENP), one streaming nurse and five health care assistants. Planned staffing for the night shift was eight registered nurses and two health care assistants which has been increased to three due to demand. Two emergency nurse practitioners worked every day within the minors department assessing and treating patient with minor injuries and illnesses from 8am to 10pm.

When the planned cover was not achievable, the shift leader would generate an indicator to identify the level of risk to the department. Senior managers and ward manager told us that it would be managed as a ‘red flag’ and escalated to be one of the areas that was required to be filled first with staff. This meant that it would be covered by bank, agency or staff from other areas.

During the day the registered nurses were allocated to specific roles and areas for the duration of their shift. The majors area was split by cubicles into two teams; red team and blue teams to provide consistency for patients. There was also a registered nurse as shift lead. Staff reported that this was embedded and successful. This allowed staff to provide consistency throughout an ongoing period. On each shift there was a shift lead who would oversee the department, review patient status and report to the trust’s safe staffing briefings the current situation within ED.

Dedicated registered nurses were provided within the ambulance assessment area to provide a review of the condition and routine investigations and were then moved to the appropriate area within the department.

We looked at four weeks of nursing rotas to review the planned and actual registered nurse figures. Most days were covered with ten registered nurses within the day with the exception of eight days where this had reduced to nine. At night, planned numbers of eight registered were met for most nights except for seven. On each shift bank and agency would be used to meet the nursing planned requirements. There was a high reliance on bank and agency use; sometimes between 21% and 50% each week. We saw that from April 2018 to May 2018, bank or agency staff were requested for 72 out of 144 night shifts. Staff told us they felt there was enough staff on duty during the day but felt at night it was difficult to manage the work load. Staff told us there had been a reduction in the need for agency nurse cover in previous weeks.

Annual turnover rates for nursing staff in urgent emergency care from February 2017 to January 2018 are shown below, by site.
The trust had an annual turnover rate of 7.4% for nursing staff in urgent and emergency care, which was lower than the trust’s target of 9.4%. Scunthorpe General Hospital did not meet the trust’s target for turnover rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates for nursing staff in urgent emergency care from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>842.67</td>
<td>14,641.44</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 5.5% for nursing staff in urgent and emergency care, with 5.8% at SGH, which was higher than the trust’s target of 4.1%. (Source: Routine Provider Information Request (RPIR) P19 Sickness)

The nursing bank and agency staff usage by site is shown below:

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0</td>
<td>238</td>
<td>243</td>
<td>622</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>1,306</td>
<td>441</td>
<td>187</td>
<td>2,503</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018 there were a total of 3,228 nursing shifts filled by bank or agency staff in urgent and emergency care, which represented 33.6% of all available shifts and 7.6% of all shifts, remained unfilled.

At Scunthorpe General Hospital there were a total of 1,985 nursing shifts filled by bank or agency staff in urgent and emergency care, which represented 35.8% of all available shifts and 7.8% of all shifts, remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

The trust reported their medical staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>56</td>
<td>63.4</td>
<td>56.4</td>
<td>63.5</td>
</tr>
</tbody>
</table>

The trust had a 12.7% over-establishment of medical staff in urgent and emergency care in January 2018.
Trust's standard for consultant cover was from 8am to 10pm Monday to Friday. On weekends consultant cover was from 8am to 2pm. Outside of these hours, consultants were on call. This did not meet the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day. Staff told us that consultants were readily accessible on call, willing to help and would attend the department when needed. Night time cover was provided by two middle grade and one junior doctor.

We reviewed the medical staffing and there were four permanent and two fixed term consultants. This did not meet the RCEM medical staffing requirements that identified there should be a minimum of ten consultants per ED to ensure consultant cover in place from 8am to 10pm, seven days a week with some doubling up in the afternoon and weekends where demand was greater.

We looked at eight weeks of consultant rotas. We saw that only one day was not covered after 5pm. Staff said that overall the consultant cover was achieved and that consultants were visible in the department.

As of December 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 29 whole time equivalent staff working in Urgent and Emergency Care at Northern Lincolnshire and Goole NHS Foundation Trust**

```
<table>
<thead>
<tr>
<th>Staff group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>31%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>14%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>18%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)
```

The bank and agency staff usage from February 2017 to January 2018 is shown below, by site:

**Scunthorpe General Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>21</td>
<td>2</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>Doctor in Training</td>
<td>170</td>
<td>342</td>
<td>66</td>
<td>578</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>477</td>
<td>1104</td>
<td>58</td>
<td>1639</td>
</tr>
</tbody>
</table>
In urgent and emergency care, from February 2017 to January 2018, a total of 1,287 medical and dental shifts were filled by bank staff and 3,770 shifts were filled by locum staff. There were 272 shifts that remained unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

There was difficulty in recruiting to the middle grade medical positions and there were several vacancies at this level. Senior management offered permanent and fixed term contracts to staff. The majority of middle grade staff were regular locum doctors. To attract more middle grade doctors the trust had introduced a local CESR (Certificate of Eligibility for Specialist Registration) programme to encourage new staff to apply to the trust and offer a route for progression. One staff member was on the course and others were due to start.

We looked at five weeks of medical rotas to review the cover for middle grade doctors. Most shifts including nights had locum staff cover for middle grade doctors. Sometimes both doctors covering the night shift were regular locums. Locum cover for junior doctors was required periodically but not frequently in the period we looked at. We saw that seven shifts remained unfilled within the period we reviewed. A rota co-ordinator had been in place for approximately five weeks. Their role was to work with the medical staff to create a rota and fill in the gaps where medical staffing was not at the required levels. Staff told us that medical staff had offered to cover vacancies with extra shifts.

We spoke with physician students who were completing clinical placements within the department. They felt supported and received training, we saw consultants discussing care and treatment with them. On completion of their two-year training course they would support the medical team in providing patient care.

The department saw under 16,000 children per year (11,764 seen over last year) and did not need a consultant with sub-specialist training in paediatric emergency medicine as required by RCEM. No consultants had paediatric sub-specialist training. One consultant had been trained in paediatrics and three consultants had a focus in paediatric care.

Annual vacancy rates for medical staff in urgent emergency care from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE as at January 2018)</th>
<th>Total number of staff establishment (WTE as at January 2018)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>-7.4</td>
<td>56</td>
<td>32.1%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 38.2% for medical staff in urgent and emergency care, which was above the trust’s target vacancy rate of 6.3%. Both sites did not meet the trust’s target for vacancy rate.

Please note, while the figures for January 2018 show an over-establishment at two sites, the annual rate is calculated over the 12-month reporting period.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Annual turnover rates for medical staff in urgent emergency care from February 2017 to January 2018 are shown below, by site.
<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>0.39</td>
<td>8.25</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 2.2% for medical staff in urgent and emergency care, which was lower than the trust’s target of 9.4%. This met the trust’s turnover target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The trust did not provide sickness rates for medical staff in urgent emergency care at Scunthorpe General Hospital.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Records**

At our inspection in November 2016, we found that the quality of nursing records varied considerably and did not contain information regarding patient’s pressure area care, falls assessments or if they were offered any food or drinks.

At this inspection we found that documentation had improved. Appropriate assessments were recorded. Records had been reviewed and updated to ensure more in-depth information was recorded.

The ED nursing assessment document had a care round section which included a review of the patient’s needs over a two-hour period. This included asking a series of questions, such as if the patient needed the toilet, was the patient comfortable and offering the patient any food and drink.

We reviewed 21 patient records where the patient should have a completed and ongoing care round documented and found that 16 had been recorded. The department completed a monthly dashboard. This included care round audit results. We reviewed the dashboard from January 2018 to May 2018 and saw that 94% of patients had care rounds completed and 6% did not have anything recorded.

We reviewed 21 records where the patient should have a completed pressure ulcer assessment and found that 18 were recorded appropriately. The monthly dashboard also documented whether risk assessments were completed and whether appropriate care was given. The dashboard statistics identified that 94% of patients had completed assessments.

**Medicines**

At our inspection in November 2016, controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) balance checks were not always carried out. At this inspection, staff told us extra controls were in place due to missing medicines and twice daily stock checks for all controlled drugs were completed. We checked and saw that controlled drugs were checked and appropriately documented.

At our last inspection, fridge temperatures were not always escalated when outside normal parameters. At this inspection, we checked the fridge temperature checklists for April and May 2018 and found they were completed appropriately. There was information on the front of the fridge detailing the actions to take if temperatures were out of range. We found out of date eye drops in one fridge which were removed.
Nursing staff had a personal electronic key which monitored their access to medication. Staff kept the key on their person during the shift and staff reported this system works well.

We found emergency drug boxes were all in date and staff knew where to find these quickly in an emergency. We were told by staff that there was a robust process for restocking medicines by a pharmacist. We found medicines storage to be safe and secure.

We observed fluids contacting potassium were not stored separately however medical gases were stored appropriately.

Staff completed stock rotation, there was adequate stock supplied and it appeared well organised. The department had adequate storage.

The department used paper prescriptions. Patient group directions were in use by the senior nurses; these allow nurses who were non-medical prescribers to give patients certain medications, for example, pain relief.

An audit was completed between November 2017 and January 2018 to review whether the allergy status was completed on the ED medicine card. The findings identified that 83% (25 out of 30 charts) had been completed. The trust had indicated that they needed to improve the percentage and had rated it with an amber score. We checked 23 patient records and noted 21 records had known patient allergies documented.

**Incidents**

At our last inspection in November 2016, we saw that learning from incidents was not consistent and some staff were not aware of the duty of candour principles.

At this inspection staff recognised incidents and knew how to report them. When managers investigated incidents, they shared lessons learned and changed their practice as a result. On the resuscitation trolley we saw a note detailing learning from experience. This related to where kit should be stored following a previous critical incident.

Staff were able to tell us about incidents that occurred within the ED at Diana Princess of Wales. This was to share learning and prevent further occurrences.

Staff reported that they were encouraged to report incidents and that feedback was discussed at daily huddles.

Staff were aware of the statutory duty of candour principles. The department had a system in place to ensure patients were informed, given an apology when something went wrong and were told of any actions taken as a result. Staff were able to give examples of when duty of candour had been applied.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from March 2017 to February 2018.
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from February 2017 to February 2018 within urgent and emergency care.

Is the service effective?

Evidence-based care and treatment

Department policies were based on National Institute for Health and Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines. Up to date NICE guidance was displayed in the department for staff to review. Articles of interest were also available in the department for staff to review.

A number of clinical pathways were used to support staff in complying with all aspects of best practice guidance when treating patients. We found that four of these pathways had not been reviewed, these were the same pathways that were identified at our inspection in 2016. These included community acquired pneumonia bundle, blood transfusion, recognition of strokes and rapid access chest pain referral. One of these had a review date of February 2015. Two other pathways did not have a review date to re-evaluate them; these included fast track hip fractures and standard operating procedure for management of patients with mental health presentations within ED. We looked at a further 11 pathways which were up to date and contained relevant information.
Patient Group Directions (PGD) were in place which allowed staff to administer medicines to patients without a prescription from a doctor. Staff were using the PGDs although there were not current up to date signatures for new staff starting within the department. The PGDs contained evidence-based information however the majority were due to be reviewed in 2017 and had been extended to be reviewed in August 2018. This meant that they may not contain up to date relevant information.

The trust participated in the national RCEM audits to monitor standards of care and benchmark its practice against other emergency departments. Action plans were in place to improve areas in the audits that were not at the required level. Additional audits were completed to provide levels of assurances to the trust. We saw that the range of assurance changed depending on the audit results.

A range of evidence-based risk assessments and tools were used across the department. These included Situation, Background, Assessment, and Recommendation (SBAR): a document that was used to facilitate, prompt and appropriate communication especially amongst doctors and nurses.

Staff reported that the internal hospital guidelines for accepting referrals from the department had been developed with the hospital surgeon. We were told that the department had developed better communications with surgical teams through regular meetings.

We saw staff completing nursing procedures with patients that followed evidence-based care and treatment. Staff were aware of policies and procedures and how to find them through the trust intranet. These were regularly reviewed. We reviewed four policies which were all in date and referenced with the latest evidence base guidance. We observed the Clinical Institute Withdrawal Assessment for Alcohol recorded on some alcohol dependant patients however; we could not see how staff had identified their reasoning.

**Nutrition and hydration**

At our last inspection in November 2016, we did not see patients routinely offered food and drinks. At this inspection we saw that patients were provided with food and drink regularly. The department had introduced hydration stations which were accessible for patients and family members. Various staff reported that the hydration stations had been a positive change.

We observed patients being offered food and staff assisting patients to eat. There were various sandwiches and juices available for patients. We saw that meals were provided for patients that had been in the department for an extended period of time. In the waiting room there were vending machines with a selection of drinks and snacks.

As part of the care rounds which healthcare assistants completed they reviewed whether a patient required any food and drink. This was recorded in the patient’s record and we saw evidence that these were completed. The number of healthcare assistants had increased in the department which gave additional capacity for them to provide care to patients. We saw that they provided support to patients who were unable to manage independently.

The department completed a dashboard monthly; this included auditing records to identify if food and drink were offered to patients where appropriate. We reviewed the audits from January to May 2018 and found the majority of patients (94%) had been offered food and drink.

Staff told us baby food could be accessed from the children’s ward if needed.

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.
Pain relief

At our inspection in November 2016, pain scores were not always recorded. At this inspection we reviewed 23 patient records including 10 paediatric records. We checked if a pain score was recorded this was to assess if a patient had pain, what the level of pain was and whether they required pain relief. Out of the sample we looked at 13 had a pain score recorded, two was not applicable and 12 were given analgesia.

We spoke with five patients who all told us they were offered medication for pain relief. We also observed patients being offered pain relief.

The department completed a dashboard monthly; this included auditing records to identify if pain scores and analgesia was recorded. We reviewed the audits from January to May 2018 and found that 93% of patients had their pain score completed and recorded. In April 2018, it identified that 87% had a pain score completed. It identified that 88% patients received timely pain relief. The dashboard looked at whether pain scores were reviewed; 87% had a pain score reviewed and 13% were not completed.

An audit by the trust was completed between November 2017 and January 2018 to review the recording of pain relief. The audit monitored whether a pain score and initial assessment was completed. The findings showed that 100% of records (28 out of 28) identified that this had been completed. It also identified whether the pain assessment had been documented and acted upon accordingly. This showed that 55% of records (16 out of 29) had the documentation completed. This meant that 45% had not had this completed; as a result, it had been indicated as a red risk on the audit chart.

The department had access to a variety of medications used for pain management. A PGD was used for various pain medicines. This allowed patients to receive adequate pain relief when patients were triaged and awaiting further assessment by the medical team. Pain scoring tools were used for both adults and children. Different pain scales were used for children and were adapted more appropriately for their age. For example, pictures of faces identified pain scales for smaller children.

In the CQC Emergency Department Survey, the trust scored 5.2 for the question ‘How many minutes after you requested pain relief medication did it take before you got it’? This was about the same as other trusts. The trust scored 7.2 for the question ‘Do you think the hospital staff did everything they could to help control your pain’. This was about the same as other trusts.

Patient outcomes

The Royal College of Emergency Medicine (RCEM) has a range of evidence based clinical standards to which all emergency departments should aspire to achieve to ensure optimum clinical outcomes. During our previous inspection the department was failing to meet all of the 100% standard that was set.

A selection of the RCEM audit action plans were on display which identified where the department had improved and required further improvements. The trust’s audit department completed additional audits such as sepsis and streaming and the results were displayed. The RCEM audits were discussed in the trust’s audit meetings. We observed action plans were in place to address findings and recommendations from the audits. Further audits were identified, the topics were confirmed and lead doctors chosen.
Evidence from the adult sepsis audit was on display in the department and this showed areas where there could be improvements and what they did well. The audit identified whether patients received their antibiotics within one hour. From August 2017 to March 2018 six months it was 100% compliance, other months ranged between 90% and 95%.

The streaming of patients was also audited following implementation of the streaming service standard operating procedure (SOP). The audit reviewed patients between December 2017 and January 2018. This identified that 80% (24 out of 30 patients) were seen and assessed within 15 minutes of arrival. The trust had rated this as amber.

**RCEM Audit: Moderate and Acute Severe Asthma 2016/17**

Scunthorpe General Hospital

In the 2016/17 moderate and acute severe asthma report, Scunthorpe General Hospital failed to meet any of the seven relevant standards.

However, the hospital was worse than other hospitals (in the lower UK quartile) for the following three standards:

- **Standard 3**: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 8.0%; 25%.
- **Standard 4**: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy. Hospital: 61.0%; UK: 77%.
- **Standard 9**: Discharged patients should have oral prednisolone prescribed according to guidelines. Hospital: 20.0%; UK: 52%.

The hospital was similar to other hospitals (between the upper and lower UK quartiles) for the remaining four standards:

- **Standard 1a**: O2 should be given on arrival to maintain oxygen saturation of 94-98%. Hospital: 16.0%; UK: 19%.
- **Standard 2a**: Vital signs should be measured and recorded on arrival at the ED. Hospital: 24.0%; UK: 26%.
- **Standard 5a**: If not already given before arrival to the ED, steroids should be given within one hour of arrival (acute severe). Hospital: 22.2%; UK: 19%.
- **Standard 56**: If not already given before arrival to the ED, steroids should be given within four hours of arrival (moderate). Hospital: 20.0%; UK: 28%.

**RCEM Audit: Consultant sign-off 2016/17**

Scunthorpe General Hospital

In the 2016/17 Consultant sign-off audit, Scunthorpe General Hospital failed to meet any of the four relevant standards.

However, the hospital was better than other hospitals (in the upper UK quartile) for one standard:

- **Standard 2 (developmental)**: Consultant reviewed – fever in children under 1 year of age. Hospital: 28.6%; UK: 8%.

The hospital was worse than other hospitals (in the lower UK quartile) for the following two standards:

- **Standard 1 (developmental)**: Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Hospital: 3.5%; UK: 11%.
- **Standard 4 (developmental)**: Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 3.9%; UK: 10%.
However, the hospital’s result for the remaining standard was similar to other trusts (between the upper and lower UK quartiles):

- **Standard 3** (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Hospital: 11.4%; UK: 12%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Scunthorpe General Hospital

In the 2016/17 severe sepsis and septic shock audit, Scunthorpe General Hospital failed to meet any of the eight relevant standards.

However, the hospital was better than other hospitals (in the upper UK quartile) for one standard:

- **Standard 1**: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Hospital: 94.7%; UK: 69.1%.

The hospital was worse than other hospitals (in the lower UK quartile) for the following six standards:

- **Standard 3**: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 2.6%; UK: 30.4%.
- **Standard 4**: Serum lactate measured within one hour of arrival. Hospital: 3.6%; UK: 60.0%.
- **Standard 5**: Blood cultures obtained within one hour of arrival. Hospital: 5.3%; UK: 44.9%.
- **Standard 6**: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 5.31%; UK: 43.2%.
- **Standard 7**: Antibiotics administered: Within one hour of arrival. Hospital: 3.5%; UK: 44.4%.
- **Standard 8**: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 1.8%; UK: 18.4%.

The hospital performed similar to other hospitals (between the upper and lower UK quartiles) for the remaining one standard:

- **Standard 2**: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 71.9%; UK: 64.6%.

(Source: Royal College of Emergency Medicine)

Information received from the trust following the inspection provided evidence that there had been identified problems in the data collection for the RCEM severe sepsis and septic shock 2016/17 audit. Therefore, the trust had undertaken their own re audit and this had shown improvements.

RCEM Audit: Vital signs in children 2015/16

Scunthorpe General Hospital

In the 2015/16 Vital signs in children audit, Scunthorpe General Hospital failed to meet any of the six relevant standards.

However, the hospital was worse than other hospitals (in the lower UK quartile) for one fundamental standard and one developmental standard:
• Standard 1a (fundamental). All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Hospital: 17.0%; England: 37.6%.
• Standard 5 (developmental). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). Hospital: 33.3%; England: 60.0%.

The hospital performed similar to other hospitals (between the upper and lower England quartiles) for the remaining four standards:
• Standard 1b (developmental). All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of capillary refill time. Hospital: 17.0%; England: 22.5%.
• Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. Hospital: 5.6%; England: 4.4%.
• Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Hospital: 61.1%; England: 69.7%.
• Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital: 66.7%; England: 73.2%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16

Scunthorpe General Hospital

In the 2015/16 Procedural sedation in adult’s audit, Scunthorpe General Hospital met one of the seven relevant standards with 100% of procedural sedations taking place in a resuscitation room or a room with dedicated resuscitation facilities (standard 3).

However, the hospital was better than other hospitals (in the upper England quartile) for two fundamental standards:
• Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Hospital: 100.0%; England: 90.0%.
• Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  7a: Return to baseline level of consciousness.
  7b: Vital signs within normal limits for the patient.
  7c: Absence of respiratory compromise.
  7d: Absence of significant pain and discomfort.
  7e (developmental): Written advice on discharge for all patients.

  Hospital: 31.4%; England: 2.6%.

The hospital’s results for the remaining five metrics were similar to other hospitals (between the upper and lower England quartiles):
• Standard 1 (fundamental): Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
1a: ASA grading
1b: Prediction of difficulty in airway management
1c: Pre-procedural fasting status

Hospital: 2.0%; England: 7.6%.

- Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Hospital: 50.0%; England: 51.8%.

- Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  4a: A doctor as sedationist
  4b: A second doctor, ENP or ANP as procedurist
  4c: A nurse

Hospital: 60.0%; England: 40.8%.

- Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
  5a: Non-invasive blood pressure
  5b: Pulse oximetry
  5c: Capnography
  5d: ECG

Hospital: 10.0%; England: 23.9%.

- Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Hospital: 26.0%; England: 41.0%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

Scunthorpe General Hospital

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit, Scunthorpe General Hospital scored 0.0% for standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. This was worse than the England median of 2.0% and failed to meet the national standard of 100%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From February 2017 to January 2018, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5% and worse than the England average in 11 out of 12 months.

The trust’s unplanned re-attendance rate ranged from 8.0% to 10.0% compared to an England average range of 7.5% to 9.1%. In the most recent month (January 2018) the trust reported an unplanned re-attendance rate of 9.3% compared to an England average of 7.6%.

Unplanned re-attendance rate within 7 days - Northern Lincolnshire and Goole NHS
Competent staff

New staff accessed a one-week induction called ‘care camp’ which included objectives and expectations required by both the staff and trust. New starters to the trust told us they felt supported and that they completed competency packages for certain skills and procedures.

There was a time period for staff to train and complete the package PGD which would be followed up by the clinical lead that assessed the staff’s competencies. The staff member would then be assessed by a clinical lead before being deemed competent. Staff told us that they were observed and signed off to say that they had met the competencies needed.

We spoke with four new starters who told us that they had received a period of supernumerary time to develop and learn their role. Staff did identify that they found it difficult to access training whilst at work and that some would be completed in the staff’s own time when the courses were not mandatory.

Bank and agency staff would receive an induction on their first time working within the department. We spoke with bank and agency staff who confirmed this. The ward manager told us that agency staff required a specific level of skills to work within the department and this would be agreed with the agency prior to booking.

There were no registered sick children’s nurses (RSCN) working in the department. We asked staff how they were assured that there was sufficient specialist training and skills in children’s care for the department who stated they completed a paediatric competency booklet. We requested information from the trust regarding training specifically for children, this contained mandatory training for resuscitation and safeguarding. No further or additional courses had been completed for children’s conditions or illnesses. This meant that we were not assured that staff had the appropriate skills to manage paediatric conditions. We were also not assured that each shift contained an appropriate level of registered staff that had completed paediatric resuscitation.

Teaching sessions were offered in the department weekly and were attended by both medical and nursing staff. We saw a teaching session led by a consultant taking place which reviewed different types of back pain that patients had been attending the department with. There were ongoing training sessions specifically for emergency nurse practitioners and doctors, with the itinerary on the training board, for example they had received training regarding femoral blocks.
(localised anaesthetic) for patients with a fractured neck of femur to give them pain relief.

Staff reported that there were opportunities available for professional development. Two emergency nurse practitioners (ENP) were currently doing training to become advanced nurse practitioners. This role would support the medical team with diagnosing and reviewing patients. Senior managers were reviewing whether the inclusion of the nurse associate would bring additional benefits to the department. This role would support the nursing team with managing and reviewing patients.

External medical technology companies provided training to staff for medical devices. There were no competencies for medical device training but the senior managers had identified that this was an area that they needed to complete.

Since the last inspection the band six staff rotated their responsibilities and worked in different roles. These included shift lead, streaming nurse, co-ordinator and clinical role whereas previously they worked as the co-ordinator all the time. Staff told us that the variety in the role had decreased stress levels and increased their clinical skills.

From April 2017 to January 2018 65.9% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 95%.

A split by site and staff group can be seen in the graph below:

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>11</td>
<td>9</td>
<td>95%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Qualified Nursing Staff</td>
<td>39</td>
<td>28</td>
<td>95%</td>
<td>71.8%</td>
</tr>
<tr>
<td>Medical Staff – Hospital</td>
<td>12</td>
<td>7</td>
<td>95%</td>
<td>58.3%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>18</td>
<td>8</td>
<td>95%</td>
<td>44.4%</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital had a 65.0% appraisal completion rate overall for urgent and emergency care with no staff group meeting the 95% appraisal completion target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

We observed the staff working together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care. We observed effective communication between nursing and medical teams. Various meetings took place daily to aid communication between the different disciplines. These included two hourly board rounds, safety huddles and operational meetings. The safety huddle monitored the capacity within the department, discussed patients, any that had been there for a long period of time and what actions were required to discharge or admit the patients. Staff allocation was reviewed to ensure staff knew their roles and responsibilities for the shift.

At the safety huddles certain information was discussed such as new policies, feedback, complaints, investigations and staff recognition; medical and nursing staff attended these. We attended a safety huddle and a quality and safety meeting. The quality and safety meetings were
led by the consultant on the department and the majority of staff attended. Staff told us the safety huddles took place daily and felt they were effective.

Board rounds were completed every two hours. We observed part of a board round which was co-ordinated and led by one of the consultants. They discussed the patients in the department including their ongoing plan of care, waiting times and any referrals they were waiting for.

There was a frail elderly assessment team (FEAST) in place and they attended the board rounds to identify and support elderly patients. This multi-disciplinary team could reduce the amount of time frail patients needed to spend in hospital. Social workers were based onsite who could access intermediate care beds when appropriate. Clinical nurse specialists attended the department to provide clinical expertise and review patients if needed, for example diabetes nurse specialists would review patient’s care needs. The mental health liaison team reviewed patients with mental health needs and provided timely assessments.

At the time of our inspection the hospital was at operational pressure escalation level (OPEL) three, we saw various disciplines attend the department to support the flow of patients. We saw that pharmacy, discharge co-ordinators, physiotherapists attended to identify if they could review, support or discharge patients.

**Seven-day services**

The department was operational 24 hours a day, seven days a week. Other facilities could be accessed 24 hours such as X-rays, pathology, CT and MRI scans. Pharmacy and physiotherapy services were available seven days and an on-call service was provided.

There was 24-hour access to adult mental health teams. Staff were aware of how to contact the teams and staff said they responded quickly to patients.

**Health promotion**

Staff provided advice to patients and families regarding health promotion and access to services. Staff took the opportunity when appropriate to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients. The staff were not aware of any alcohol link nurse in the department but they had leaflets available to access the helpline.

The department provided patients with information leaflets about their condition and any aftercare required, such as from falls or head injuries. These could be directly printed off the computer.

Discharge advice was given to patients / carers to allow patients to safely manage their condition at home or where to seek further advice if appropriate.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff we spoke with demonstrated a good knowledge of the Mental Capacity Act in relation to their role and obtaining consent from patients. Staff told us if a patient refused treatment or they had any concerns regards capacity then it would be raised with the doctor.

We reviewed records to identify if mental capacity information was assessed and recorded. Out of 12 records, 11 had completed information about mental capacity.

When asked about patients who attended with mental health issues staff told us that if a patient was not presenting as high risk or acutely unwell they would ask for consent before making a
referral to the mental health liaison service if they had identified a potential mental health difficulty for example depression.

Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.

Staff we spoke with who were looking after children were aware of the Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children. The ‘Gillick Test’ helps clinicians to identify if children aged under 16 years have the mental capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Is the service caring?

Compassionate care

At our inspection in November 2016, we saw examples that patient’s general needs were not met. At this inspection we saw, that due to the introduction of care rounds, patient’s basic care needs were being met. We observed many interactions between staff, patients and relatives. Staff were always polite, respectful and professional in their approach.

We observed staff responding compassionately to patients’ pain, discomfort, and emotional distress in a timely and appropriate way.

A new call bell system had been introduced so staff could identify and then respond to patients’ needs promptly.

We spoke with 13 patients and six relatives who told us that they found staff to be caring, they were kept comfortable and always felt respected.

Staff closed curtains and doors when patients were receiving care and treatment. We saw that staff were courteous and introduced themselves to patients. In relation to patients who attended with mental health issues we observed staff demonstrated a non-judgemental attitude towards patients and assessed patients’ needs on an individual basis which would include both mental and physical health.

The trust’s urgent and emergency care Friends and Family Test (FFT) performance (percentage of patients who recommended the department) was consistently worse than the England average from January 2017 to December 2017. However, the trust’s FFT score improved over the reporting period with 83.4% of patients recommending the trust in December 2017 compared to the England average of 85.5%.
Emotional support

We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.

Patient’s families were supported after bereavement. There was support available for people who were bereaved from the multi-faith chaplaincy service. The spiritual needs of patients could be met through a 24-hour chaplaincy support.

We saw that bereavement boxes could be provided for children where family members could store items. Families were offered other memorable items such as children’s foot printing.

Understanding and involvement of patients and those close to them

Patients told us staff ensured they understood medical terminology. Patients who used the service felt involved in planning their care, making choices and informed decisions about their care and treatment. We observed staff communicating in a way that people could understand and was appropriate and respectful.

We observed that medical staff generally took time to explain to patients and relatives the effects or progress of their medical condition and treatment options. Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for. We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.

The department completed a dashboard monthly; this included auditing records to identify if patients were kept informed. We reviewed the audits from January to May 2018 and found that it identified the majority of patients (98%) were kept informed.

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the</td>
<td>4.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Is the service responsive?

Service delivery to meet the needs of local people

Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. For example, the service worked with external partners to plan the new streaming process at the front door, this was in line with the RCEM guidance on how to achieve safe, sustainable care in emergency departments.

Senior managers were reviewing the medical model required in the hospital to ensure that patient demand was met due to the increasing numbers of patients attending the department.

An agreement was in place with the GP primary care provider in the department that the trust would cover any gaps in their rota. This meant that patients were being seen in the most appropriate place and not impacting on capacity within ED.

The department had developed networks with external providers to deliver increased mental health provisions for the local population. This included providing 24 hours a day access to a mental health liaison team including rapid assessment of patients with mental health needs within one hour.

The separate children’s waiting room provided good segregation for children away from the adults waiting area. There was adequate seating and availability to treatment rooms in all areas of the department. However, there was no screen or signage to inform patients how long their wait would be in the children’s waiting area.

Meeting people’s individual needs

People’s individual needs were identified and recorded. There was an electronic system that was used to alert staff of any individual needs that a patient may have. For example, an alert could be added to the system for a patient who had learning disabilities or was living with dementia. There was no separate cubicle in majors area for patients who attended with dementia or learning disability; staff described caring for them in the mental health assessment room near the nurses’ station so they could be observed and encouraged carers to accompany them.

Staff told us that there was reminiscence box and sensory equipment for patients with dementia to help distract and comfort patients with dementia. Specialist services were available for staff to access and attend the department, these included LD, diabetic and dementia link nurses. Contact details were available throughout the department which included who to contact also out of hours.

| Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home? | 4.8 | Worse than other trusts |
| Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department? | 7.2 | About the same as other trusts |
| Q45. Overall... (please circle a number) | 8.1 | About the same as other trusts |

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
The department was wheelchair accessible. The department had new toilets which included separate disabled, female and male toilets. Staff stated that the department had good access to bariatric equipment and they could use the hoist, if required, that was on site.

There was a telephone interpretation service which staff could use with patients and staff could access an interpreter if needed. In the entrance area there was a notice board with ‘welcome’ in different languages.

The department had a relative’s room with access to a telephone and drinks. There was an information booklet available for relatives for advice on what to do if they had suffered bereavement. The department had a dedicated viewing room.

The trust scored about the same as other trusts for all three Emergency Department Survey questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Access and flow

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust failed to meet the national standard in any of the 12 months from February 2017 to January 2018. From February 2017 to January 2018 the trust performed worse than the England average in eight out of the 12 months. The trust’s performance improved over time with the percentage of patients admitted, transferred or discharged within four hours being higher than the England average from October 2017 to January 2018.

Four-hour target performance - Northern Lincolnshire and Goole NHS Foundation Trust

(Source: NHS England - A&E waiting times)
Median time from arrival to treatment (all patients)
The Royal College of Emergency Medicine recommends that the time patients should wait from
time of arrival to receiving treatment is no more than one hour. The trust met the standard for five out of the 12 reported months from February 2017 to January 2018.

Performance against this standard showed a trend of improvement with the trust reporting a median time from arrival to treatment of less than 60 minutes for the most recent four months (October 2017 to January 2018). In the most recently reported month the trust has a median time to treatment of 59 minutes compared to an England average of 57 minutes.

Ambulance – Time to treatment from February 2017 to January 2018 at Northern Lincolnshire and Goole NHS Foundation Trust

We reviewed 40 records for the time from arrival to treatment. In 21 records patients were seen within one hour. A further 14 patients were seen within two hours. Four patients were seen between two and four hours. In one record the time was not documented therefore it was difficult to ascertain the time they were seen.

At our last inspection in November 2016, we had concerns regarding patient flow and how it impacted on patient safety. At this inspection we saw that changes had been made in the department that had shown improvements to patient flow. Since our last inspection the department had introduced a streaming nurse; they sat next to receptionist and decided which part of the service was most appropriate. A patient flow co-ordinator supported the team to ensure that patients received timely investigations and treatment.

The senior management team monitored flow within the hospital and meetings took place to understand the bed availability within the hospital; this enabled improved planning for expected admissions and discharges and ensured patient flow throughout the hospital was timely. The shift lead would attend the meeting and provide an update of the current demand within the department. This would include providing details of how many patients were in the department, number of ambulance delays, waiting and breach times.

There was an escalation and surge policy which provided guidance on when and how to activate the policy. The aim of the escalation policy was to ensure safe working when the department was full or the hospital bed availability was preventing the flow of patients through the department. The policy described specific escalation triggers and had an explanation of various levels of alert across the acute trust, community care, social care, primary care and other health care systems.

Within the escalation and surge policy it identified measures to support ED. This included ‘10 steps to improving the emergency care pathway’, however, this was not always followed. For example, it identified that speciality doctors must have arrangements in place to review patients within 30 minutes of the referral from ED. If the requirement could not be achieved the ED consultant on duty or on call had the authority to admit the patient to the appropriate speciality.
ward. Medical staff within ED told us that speciality doctors would not always attend within 30 minutes and would not always accept the patient that the ED consultant admitted to the speciality ward. We reviewed weekly ED flow meeting minutes and saw in February 2018 that surgical doctors were refusing to accept patients until there was a vacant bed for them. At our meeting with the divisional clinical director we were told that further work needed to be developed.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted.**

From February 2017 to January 2018, Northern Lincolnshire and Goole NHS Foundation Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average for six out of the 12 months. The trust’s performance improved over time with the trust reporting a lower percentage than the England average from August 2017 to January 2018.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - Northern Lincolnshire and Goole NHS Foundation Trust.**

(Source: NHS England - A&E waiting times)

There was an overflow area next to the ambulance entrance for ambulance crews awaiting handover. From the daily situation report, the number of patients waiting between four and 12 hours from decision to admit has reduced from 31% in February 2017 to 13% in February 2018.

**Number of patients waiting more than 12 hours from the decision to admit until being admitted.**

Over the 12 months from February 2017 and January 2018, one patient waited more than 12 hours from the decision to admit until being admitted.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients over four hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-17</td>
<td>749</td>
<td>1</td>
</tr>
<tr>
<td>Mar-17</td>
<td>465</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>651</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>351</td>
<td>0</td>
</tr>
<tr>
<td>Month</td>
<td>Median Time in A&amp;E</td>
<td>Patients Seen Before Treatment</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Jun-17</td>
<td>405</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>356</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>140</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>262</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>147</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>202</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>254</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment.

From February 2017 to January 2018 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was generally better than the England average.

The trust’s performance improved over time with 3.1% of patients leaving the trust before being seen in February 2017 compared to 0% in December 2017 and January 2018.

Percentage of patients that left the trust without being seen - Northern Lincolnshire and Goole NHS Foundation Trust.

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients).

From February 2017 to September 2017 the trust’s monthly median total time in A&E for all patients was generally similar to the England average. The trust reported an improved performance from October 2017 to January 2018 with a lower median total time in A&E than the England average.

In January 2018 the median total time in A&E was 146 minutes which was lower than the England average of 153 minutes.

Median total time in A&E per patient - Northern Lincolnshire and Goole NHS Foundation Trust.
Learning from complaints and concerns

The trust had a complaints policy which was located on the intranet for staff to access if needed. The department had a complaints response process that addressed both formal and informal complaints, which were raised through the Patient Advice and Liaison Service (PALS).

Staff told us they were aware of how to deal with complaints and that they received feedback. Learning from complaints was discussed individually and discussed in the clinical governance group meetings. Any learning from complaints was shared with staff and discussed at safety huddles.

Patients and relatives, we spoke with were confident about how to make a complaint to the trust although none of the people we spoke with complained about the department.

Scunthorpe General Hospital

From 7 February 2017 to 7 February 2018 there were 40 complaints about urgent and emergency care services at Scunthorpe General Hospital.

The trust took an average of 41 working days to investigate and close complaints. The trust has three targets for closing complaints. The trust has a target to close complaints within 30 working days and a further target of 45 working days. Only 37% of all closed complaints in urgent and emergency care were closed in 30 working days and 47% of closed complaints were closed within 45 working days.

The trust has a target to close more complex complaints within 60 working days. Of all closed complaints (complex and non-complex) 77% were closed within this target.

The most complained about subjects at this hospital for urgent and emergency care services were:

- Patient care – 28 complaints (70.0%)
- Staff values and behaviour – four complaints (10.0%)
- Admissions and discharges (excluding delayed discharge due to absence of care)
package) – three complaints (7.5%).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

At our inspection in November 2016, we issued the trust with a Section 29A warning notice which stated that the quality of health care provided by the trust requires significant improvement. We had significant concerns relating to staffing shortages, lack of escalation, lack of patient assessments and insufficient management oversight within the emergency department. We undertook an unannounced inspection in June 2017 where we found there remained some significant concerns regarding the issues raised. At this inspection, we found that there had been improvements noted in the concerns raised. However, we did find that there were other areas of concerns that the department had not realised.

The emergency department was part of the directorate of operations - medicine. The leadership team for this directorate included an associate chief operating officer, divisional clinical director and associate chief nurse. The associate chief nurse had changed since our last inspection in November 2016. The directorate was split into three groups and ED was in the acute group along with assessment medical unit, short stay ward, ambulatory care unit and care of the elderly wards.

The senior leadership team in the department consisted of a medical clinical lead, department manager and operations manager. The leadership team were visible on the department with the ward manager and medical clinical lead providing clinical care to patients in the department.

A shift lead had been introduced on to each shift to allow them to take a leadership role within the department. The shift lead’s responsibilities were to complete a clinical walk round every two hours of the department to review the care and needs of the patients in the department. The shift lead would provide input into the two hourly board rounds and complete information into the activity, staffing and hazard (ASH) matrix. This fed into the operation meetings to inform the trust of the level of activity and issues within the department.

The senior management team acknowledged that improvements had been required in ED and the warning notice had provided them with a focus of where to improve. They felt that the issues faced by ED were now supported throughout the hospital and the ED was not left in isolation to manage the issues. Staff also told us that they felt supported by the new processes in place. The escalation and surge policy and ASH matrix provided evidence of the current demand in ED. It allowed the hospital to respond when the demand in ED was high and staff were brought into the department to help with the access and flow of patients. During our inspection we saw that the department was under extreme pressure and the ASH matrix reflected the concerns. We saw that staff from other departments came to ED to provide support to both patients and staff.

Vision and strategy

The team had a vision and were striving to improve on standards. The ethos of the department had changed in the view that when the department was under extreme pressures other departments around the hospital would provide additional support.

The management team worked flexibly to look at new and innovative ways of delivering patient care. We reviewed ED weekly flow meetings where it identified that a medical business plan had been created, this included eight consultants for both hospital sites. The triumvirate completed a business case that was presented to the trust management board in February 2018 regarding increasing the number of medical staff. The paper also discussed further developments to the
nursing workforce such as advance care practitioners (ACP) due to the national shortage of junior doctors.

**Culture**

There had been many changes to the department over the last 12 months such as staffing and records which had provided improvements. Staff felt supported at work generally, however at times there was pressure on the department due to the high volume of patients and demand and this lowered morale. Volunteers in the department also told us that they felt included and part of the team.

Senior leaders, department managers and shift leads were proud of their staff and praised them in their work. They told us that staff often went above and beyond to provide care to patients when extreme pressures had been placed on the hospital.

The medicine group supported medical staff and provided quality and safety meetings which allowed staff to learn from incidents and focus on quality improvement and patient safety.

Staff success was celebrated through trust events where individuals and departments could be nominated. Nominations from both staff and patients allowed staff achievements to be recognised and rewarded. However, we were not told of any staff specific to ED who had participated and nominated for any awards.

Staff were supported following specific patient complications or incidents. This included debrief sessions and included other agencies such as safeguarding and ambulance staff.

**Governance**

The medicine group had a clear governance structure. Governance structures were in place that provided assurance of oversight and performance against safety measures. We reviewed the quality governance and assurance committee minutes and found discussion around current risks and performance.

A weekly ED flow meeting was in place where performance, ambulance handovers and any other relevant information was discussed.

The shift lead would complete daily checks to provide assurances that the appropriate care was being given to patients. These included reviewing one set of care records in each area to identify assessments were completed such as care rounds. We reviewed the checklists which identified these had been completed.

An ED dashboard was in place that allowed certain information over a month to be reviewed. This mainly covered documentation of nursing records and it reviewed the patient’s observations, assessments and experience. Some of the responses were ambiguous, with figures not tallying and required further analysis to understand the answer. For example, in May 2018 on the dashboard it identified that out of 105 records, two presented with safeguarding concerns. It then reviewed information whether safeguarding referrals were completed for patients that presented with concerns. The response to the question identified that two indicated yes and four records identified no, with a further 99 records responding with a not applicable response. This meant that the answers were unclear and staff were interpreting the questions differently.

The ED dashboard provided assurances that certain information was completed and recorded. However, further improvements were required to increase the level to 100% assurances within the department. For example, an increase was required in the number of patients that presented with safeguarding risks to have a safeguarding referral completed. The majority of patient observations detailed on the ED dashboard were slightly lower at Scunthorpe General Hospital than Diana
Princess of Wales site. This included recording of pain relief, receiving pain relief appropriately and the completion of care rounds.

There was a paediatric and ED forum which reviewed patient cases, incidents and communication issues. Although in the April 2018 meeting there were no attendees from ED, however the meeting went ahead to review patient cases.

Joint meetings were held between both ED departments at the trust. This was to improve joint working and consistency by ensuring the same processes were followed. Joint recruitment programmes were undertaken and clinical governance meetings.

Management of risk, issues and performance

There was a departmental risk register, which measured the impact and likelihood of the risk and documented the controls and mitigations in place to manage the risk. The risk register covered the risks for the medicine group and contained risks to the generic group such as ongoing recruitment issues with medical and nurse roles. For example, it was identified that there were significant gaps in the medical rota within ED and there were actions on how to mitigate the risk. The risk was reviewed periodically to identify if there was any change. It also identified that there was a need to review the skills and experience of the staff working with children in the department and paediatric pathways were created to support staff. The risk register did not reflect that they were not meeting the RCEM guidelines regarding RSCNs and how they would increase the numbers.

We requested an up to date risk register at our inspection to identify if any new risks had been added. We found that the risk register did not contain some of the concerns we found at the inspection such as issues with escalation between specialities. This would have an impact of increasing the patient’s stay in the department and experience.

We were not assured that the department were sighted on the issues relating to no RSCNs and staff had not completed further training in paediatrics to mitigate the risk. There was no plan in place in how to recruit any RSCNs. We were not assured that the skill mix was configured to assure that on each shift there was suitable staff with paediatric resuscitation training.

A two-hourly department walk round was completed by the shift lead who assessed the department and the capacity and demand of patients. This allowed the shift lead to have an overview of the department and moved staff to specific areas to support with any increased activity or where patients may be waiting.

The shift lead would attend operational meetings that discussed the overview of each area within the hospital. The shift lead would use the ASH matrix at the meeting and create a plan to manage the department. We attended the operational meeting where the shift lead reviewed the ASH matrix with the director of operations. Patients who had been in the department for a long period of time were discussed and ongoing reviews of their care. Ambulance performance was reviewed as were national performance standards. We observed the system working to bring in additional medical support from the rest of the hospital: staff asked which specialities were in-reaching to the department and requests were made for additional help to attend the department to review patients and thus improve access and flow. We later saw speciality doctors attending the department and patients were reviewed.

Staff were aware of their role and responsibilities in the event of a major incident. Several processes were in place such as business continuity plan, escalation and major incidents. These were accessible to staff who discussed them with us. The department had equipment to deal with any chemical and biological incidents and the department completed a live training exercise in June 2017.
Information management

There were several information systems that provided the hospital with up to date information. The ED live dashboard allowed the hospital to see the number of patients that were in the department and any potential breaches of the national standards including length of stay in the department. The live dashboard could also link across to Diana Princess of Wales Hospital so that the information could be shared. When the trust’s escalation and surge policy was activated, due to increased demand in the department, a text alert would be generated by the system to inform staff in the hospital.

Electronic systems in the department allowed patient information to be uploaded and shared. There were portable electronic devices in the department that allowed staff to complete information which would show on the system. Receptionists within the department had access to the ambulance staff’s handover system and allowed them to book the patient into ED on arrival. We observed good practice in relation to information security, staff locked their computers and the systems did not show full patient details.

The department collected information to monitor and manage performance in regards to national and local indicators. These were collated into information that was shared with the team and trust board.

Staff told us they had access to information for them to undertake their roles effectively. This included access to the trust intranet where policies, procedures and protocols could be accessed and updated. Staff also had access to information about the treatment of injuries and conditions which reflected best practice guidance.

Important information such as safety alerts, incidents and changes to policies and procedures were cascaded to staff by the senior nurses in the department by email or other methods so that appropriate adjustments could be made.

Staff had access to clinical computer systems which linked to primary care. This meant that patient’s GP records could be accessed for all relevant information.

Engagement

The department participated in the friends and family test and CQC Accident and Emergency survey. In the waiting area, there was a notice board with values, and ‘you said we did’, with an example of ‘you said our waiting room needed updating, we made a new separate children’s waiting room, painted the department, got new chairs and improved vending machines’.

The department had various meetings each week such as quality and safety and quality audit meetings where staff could participate and ask questions. We observed a meeting which took place around the main area of majors. However, there was little interaction as some staff carried on with their other roles and were not listening. Not all staff were presented during the whole of the meeting.

Staff supported each other and engaged with each other through private social networking sites/groups. Information was shared in the groups as managers had identified that many staff used these groups as a preferred form of communication, for example, when extra shifts were advertised or information about changes in policies.

Staff did not participate in trust initiatives such as pride and respect campaign because the department was too busy to release any staff. The department did not supply us with any evidence to demonstrate engagement with patients who used the emergency department.
Learning, continuous improvement and innovation

Since the last inspection the executive board had invested in the department to improve and develop the service. The team had developed new roles such as nurse associates, physician students and two advance care practitioner (ACP) students that had recently commenced posts. These roles supported the doctors as they were unable to recruit into some medical positions. The introduction of certificate of eligibility for specialist registration (CESR) had commenced to attract and offer a route of progression for medical doctors, three staff were completing the programme.

Staff were encouraged to rotate into different areas to improve knowledge, confidence and understanding.

The trust was supporting their non-registered staff to apply for nurse associate roles. This included completing further education in core subjects in order to be able to apply for the course.

Medical care (including older people’s care)

Facts and data about this service

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of medical services for patients at all three of the acute hospital sites:

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

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

Admissions for the top three medical specialties were:

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

(Source: Hospital Episode Statistics)

The Trust provides comprehensive acute and non-acute medical services at Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPoW) at Grimsby, on an in-patient and outpatient basis. Outpatient services and sub-acute inpatient beds are provided at Goole District Hospital (GDH). The trust took over the provision of the Neuro Rehab at Goole District Hospital in September 2017.

Acute admissions are generally triaged through the Accident and Emergency / Emergency Department (ED) and the Acute Medical Units (AMU) prior to transfer to the relevant speciality wards. All specialities have access to a full range of diagnostics with patients attending a tertiary centre for more specialised tests or interventions. All services are Consultant led.

There are 419 medical inpatient beds located across all three sites; SGH provides 195 medical inpatient beds.
A medical service breakdown for SGH can be found below:

**Scunthorpe General Hospital:**

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary care unit (CCU)</td>
<td>Cardiology</td>
<td>13</td>
</tr>
<tr>
<td>Clinical decisions unit</td>
<td>General Medicine admissions unit including ambulatory care</td>
<td>24</td>
</tr>
<tr>
<td>Planned investigations unit</td>
<td>General Medicine</td>
<td>-</td>
</tr>
<tr>
<td>Ward 2</td>
<td>FEAST - Frail Elderly Assessment Unit</td>
<td>-</td>
</tr>
<tr>
<td>Stroke Unit (SSRU)</td>
<td>General Medicine</td>
<td>21</td>
</tr>
<tr>
<td>Ward 16</td>
<td>General Medicine</td>
<td>23</td>
</tr>
<tr>
<td>Ward 17</td>
<td>General Medicine</td>
<td>23</td>
</tr>
<tr>
<td>Ward 18</td>
<td>Haematology/Oncology</td>
<td>14</td>
</tr>
<tr>
<td>Ward 22</td>
<td>Respiratory Medicine</td>
<td>23</td>
</tr>
<tr>
<td>Ward 23</td>
<td>Gastroenterology</td>
<td>30</td>
</tr>
<tr>
<td>Ward 24</td>
<td>Cardiology</td>
<td>24</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>2 room Endoscopy unit, providing 7-day services and OOH emergency cover</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>195</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request - Acute-Sites)*

**Is the service safe?**

**Mandatory training**

**Medical/ Dental Staff**

At this inspection we found that compliance with mandatory training was poor for medical and dental staff. None of the modules at any of the hospitals achieved the 85% compliance target. Overall compliance was worse at SGH and compliance rates with most modules were very poor with only two modules having a compliance of over 50%. Disaggregated data was not available for GDH. This was collected as part of SGH data. Medical staff we spoke to however, told us that they were up to date with their training and had not had a problem accessing this. Junior doctors we spoke with told us they had received an induction and were up to date with their mandatory training. Locum staff we spoke with told us their mandatory training was provided by their employing agency and that the trust did not provide this for them.

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for medical/dental in medicine is shown below:

**Trust level**
### Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>25</td>
<td>45</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>23</td>
<td>45</td>
<td>51%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>20</td>
<td>45</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>20</td>
<td>45</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>18</td>
<td>41</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>19</td>
<td>44</td>
<td>43%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>15</td>
<td>45</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>13</td>
<td>45</td>
<td>29%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>12</td>
<td>45</td>
<td>27%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>11</td>
<td>44</td>
<td>25%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

### Nursing Staff

We found that compliance with mandatory training for nursing staff was 82% overall, an improvement on 2016 which was 77% overall. The target of 85% completion was reached in six out of 10 modules across the trust but only in three out of 10 modules at SGH. The lowest completion rate was for fire safety at SGH which had a completion rate of 69%.

Nursing staff we spoke to told they were up to date with their mandatory training and ward managers and matrons told us that there was sometimes a delay with training completion and the electronic system being updated.

We saw that ward held data indicated 85% CCU staff, 88% of ward 24 staff, 77% of ward 23 staff and 79% of Clinical Decisions Unit (CDU) staff were up to date with mandatory training at the time of inspection. In the Cath Lab mandatory training for HCAs was 100% and RNs 90%. On the stroke unit we saw that all staff were up to date with mandatory training.

A breakdown of compliance for mandatory courses for nursing staff in medicine from February 2017 to January 2018 is shown below:

**Trust level**
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>377</td>
<td>404</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>374</td>
<td>404</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>348</td>
<td>404</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>336</td>
<td>400</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>335</td>
<td>404</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>329</td>
<td>402</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>315</td>
<td>404</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>311</td>
<td>400</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>304</td>
<td>404</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>292</td>
<td>404</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>172</td>
<td>185</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>172</td>
<td>185</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>157</td>
<td>185</td>
<td>85%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>149</td>
<td>183</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>148</td>
<td>184</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>148</td>
<td>185</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>142</td>
<td>185</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>134</td>
<td>185</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>130</td>
<td>184</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>128</td>
<td>185</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

For new starters most, mandatory training was delivered through a two week ‘care camp’. There was an induction booklet for staff to use with agency staff and we saw this was in use on ward 22.

Safeguarding

The Chief Nurse was the executive lead for Safeguarding within the organisation and an operational Head of Safeguarding who was the strategic lead and manager of the Safeguarding team. The trust had three safeguarding forums for Children, Adults and PREVENT which reported into the Quality and Safety committee a subcommittee of the Board. The head of the safeguarding team reported directly to the trust’s chief nurse.

There were five safeguarding referrals from the medical wards at SGH from February 2017 to January 2018. Although there were no themes from these referrals there were elements of discharge, documentation, communication and medicine issues that were echoed in referrals from medical wards at DPoW.

The trust had safeguarding policies available to support staff; these could be accessed on the trust intranet.
Nursing and medical staff we spoke with could describe the processes they would use if they had a safeguarding concern, there were identified safeguarding leads and staff knew where to go to for advice or support. Staff told us that they attended safeguarding training and were up to date with training requirements.

The trust set a target of 85% for completion of safeguarding training. For the trust overall, medical staff compliance was between 72% and 75% for the different modules. Scunthorpe General Hospital had the lowest compliance for medical staff between 62% and 64%. Trust and SGH overall compliance for nursing staff was better at around the target of 85%.

Medical / Dental Staff

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>75</td>
<td>100</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>74</td>
<td>100</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>72</td>
<td>100</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>29</td>
<td>45</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>29</td>
<td>45</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>28</td>
<td>45</td>
<td>62%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing Staff

A breakdown of compliance for safeguarding courses for nursing staff in medicine over the same period is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>349</td>
<td>404</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>349</td>
<td>404</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>337</td>
<td>404</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>337</td>
<td>404</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>337</td>
<td>404</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>349</td>
<td>404</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>162</td>
<td>185</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>159</td>
<td>185</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>156</td>
<td>185</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**

The trust provided the results of the August 2017 patient led assessment of the care environment (PLACE) assessment. Patients gave this trust an overall score of 98% for cleanliness. This was the same as the national average.

We found wards and departments to be visibly clean and tidy. In most areas we found equipment was visibly clean and labels were used to identify ‘cleaned and ready for use’. However, there were some pieces of equipment on the clinical decisions unit (CDU) that were not labelled and we saw some nebulisers and dressing trolleys on ward 22 that were visibly dirty.

Patients and relatives told us the ward areas were cleaned regularly.

Hand-washing facilities were available on all wards we visited. Personal protective equipment (PPE) including aprons and gloves, and sanitising hand gel were also available.

We observed staff using appropriate personal protective equipment when completing clinical tasks. They complied with hands bare below the elbows national best practice, correct handwashing technique and use of sanitising hand gels was observed. However, we also observed some instances where gel was not used between patients for example when doing medicine rounds or on consultant ward rounds.

Side rooms were available on all wards. We saw notices displayed on doors where patients with infections were being cared for. Staff on the Planned Investigations Unit (PIU) were concerned that they had recently had an inpatient with wet cellulitis that they had been unable to isolate.

Staff completed infection prevention and control training; compliance for nursing staff across the medical service was 75% and 72% at SGH, below the 85% target. Medical staff compliance with this training was very poor 32% across the trust and 29% at SGH. (See mandatory training breakdown above)

We saw there were monthly infection control audits, across the trust medical wards, carried out by ward staff, matrons and infection prevention and control nurses (IPCNs). The audits looked at ten indicators including cleanliness of the environment and equipment, hand hygiene facilities, disposal of waste including sharps and clinical practice. From April 2017 to March 2018 overall compliance with the range of indicators ranged between 76% and 97%. Scores given by the IPCNs tended to be lower than those awarded by the ward staff. Compliance was mostly above 95% for hand hygiene facilities and clinical practice over the year and never fell below 85%. Compliance was more variable for cleanliness of general environment, patient equipment, storage areas, waste and linen disposal and sharps safety. The trust did not provide a breakdown by hospital site or ward.

From April 2017 to March 2018 general environment audit compliance, at trust level, was consistently the worst performance of all the infection control indicators and only scored over 90% on two occasions out of twelve, at least one of the auditors scored this indicator below 85%
(red rated) every month. The trust did not provide a breakdown of site or ward.

We spoke to infection prevention and control nurses in the CDU who told us they visited that area daily to check on screening and isolation and provide support.

**Environment and equipment**

Most wards we visited were clutter free, visibly clean and well maintained. However, we saw that storage areas on ward 22 were untidy and cluttered making it difficult for staff to find the equipment they needed.

Ward 22 had a daily checklist for staff to check that all nurse call bells, oxygen and suction equipment were working correctly; however, this had only been completed seven times in April 2018. On the same ward the last documented clean of the linen cupboard was 22 March 2018 and there were pillows on floor. The tea trolley in the dayroom was dirty with spilled sugar and open cereal containers; however, the room was bright and well equipped with comfortable chairs and had an emergency call bell. We also saw that antichlor tablets and made up solution were left out in an unlocked room.

Staff on most wards told us that they had sufficient equipment to support them to safely care for patients. This included pressure-relieving equipment and moving and handling equipment. Medical devices we looked at were labelled to indicate when it was last serviced or checked for electrical safety.

Emergency resuscitation equipment on each ward had daily checks completed in line with policy. We checked consumable items, such as gloves, oxygen masks and suction equipment and did not find any items that were out of date on the trolleys. We looked at the tamper prevention seals on the resuscitation trolleys on ward 22, 24 and the stroke unit and found that these were not numbered.

Patients on ward 17 told us that beds were changed daily and floors were cleaned daily. Stocks of equipment were stored appropriately and the ward and storage areas were clean and tidy. We did see that oxygen cylinders were not secured to the wall and were in danger of falling over.

**Assessing and responding to patient risk**

The National Early Warning Score (NEWS) is a tool that is used to alert health care practitioners to deteriorating patients and therefore trigger an escalation of care and review of the unwell patient. We saw that staff used NEWS which were recorded in the notes we reviewed. We saw that NEWS scores were calculated and patients were escalated appropriately.

The trust also used a nationally recognised sepsis-screening tool. Where applicable, we saw sepsis-screening tools in the notes we reviewed. The trust had achieved around 80% compliance with screening of appropriate acute adult inpatients for SEPSIS in the three months prior to the inspection.

Recording of physiological observations was audited and reported as part of the nursing audit dashboard. The data for November 2017 showed that medical wards at SGH were 100% compliant for vital signs recorded with the planned frequency and the appropriate response actioned. Other nursing dashboard audits were; of falls, skin, food and hydration and patient safety indicators. The dashboard for November 2017 showed that more than 95% of risk assessments were carried out within six hours of admission. Areas for improvement were following of the falls care pathway and following of the pressure area care pathway which showed 82% and 86% compliance.
We saw pink wristbands in use for patients with Chronic Obstructive Pulmonary Disease (COPD) stating what their target O2 (Oxygen) saturations were. This made it easy for staff to check if targets were being maintained.

Non-Invasive Ventilation (NIV) patients were nursed in a four-bedded high observation bay on ward 22 the respiratory ward. This area was staffed with one RN and one HCA at all times. There were specialist care plans for these patients and staff had received additional training to care for the patients and their equipment. Support was also available from critical care outreach staff if needed.

The stroke responder based on the stroke unit, was supernumerary to ensure they could respond immediately to attend patients when they arrived in the emergency department. All stroke patients had dysphagia testing in the emergency department before admission to the stroke unit and swallow recommendations were clearly displayed above the patients’ beds.

Within the care records we reviewed we saw that staff assessed patients for risk of falls, pressure damage risk, moving and handling, risk of malnutrition, use of bedrails and venous thromboembolism (VTE). We saw individualised risk-based plans of care were implemented for patients and where necessary patients had been referred to appropriate specialist teams, for example physiotherapists and dieticians. However, we noted VTE assessments were not always completed within 24 hours in line with the National Institute for Health and Care Excellence (NICE) clinical guideline [CG92].

Staff told us that doctors responded quickly when patients were escalated and there was a critical care outreach team out of hours to support the medical on-call team.

We saw staff in the cardiac catheter laboratory using a (WHO) safer surgery checklist for a patient undergoing an angiogram; the checklist had been modified for specific use with patients undergoing cardiology procedures. Staff in this area told us they could escalate sick patients immediately to a cardiology consultant or Specialist Registrar (SpR).

**Nurse staffing**

In 2016, although staffing had improved from 2015, we were still concerned about the impact of staffing levels on patients and staff in medical services. In January 2018 the trust had a qualified nursing staff fill rate of 96.2%, with 12.1 fewer whole time equivalent (wte) staff in post than the trust planned to provide safe and effective care. All three hospitals reported less staff in place than was planned. For the previous year (January 2017) the trust reported a slightly higher staff fill rate of 97.5%, however the planned whole time equivalent (wte) had risen for SGH as had the actual number of staff in post from 2017 to 2018.

The trust reported their qualified nursing staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>158.4</td>
<td>154.0</td>
<td>152.9</td>
<td>148.8</td>
</tr>
<tr>
<td>Goole District Hospital</td>
<td>13.1</td>
<td>12.8</td>
<td>13.3</td>
<td>12.4</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>145.5</td>
<td>138.2</td>
<td>133.2</td>
<td>130.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>317.0</strong></td>
<td><strong>304.9</strong></td>
<td><strong>299.3</strong></td>
<td><strong>291.7</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
Overall staff reported that they felt the nursing staffing situation had improved since the last inspection. We found that the trust had acted to ensure that acute admission wards such as the Acute Medical Unit (AMU) at DPoW and the Clinical Decisions Unit (CDU) at SGH always had adequate staffing levels. This meant that staff from other wards and departments were moved to work in these areas if staffing levels fell below those planned. We found that other specialist areas such as Coronary Care Unit (CCU) were also protected to some degree as staff were less likely to be moved to cover other areas.

CCU, Stroke unit, ward 16 and CDU met the planned staffing requirements on the inspection day.

Ward 22 had one registered nurse (RN) short (five out of six were on duty) during the day but otherwise met planned staffing levels on the day of inspection, the ward was fully staffed on the day of the unannounced inspection. Staff on this ward told us they had the highest vacancy rate in the trust and had six wte RN vacancies when they were operating 23 beds. The ward could however have 27 beds open and this would mean their vacancies were 10 RNs and 3.9 HCAs. The ward was expecting three new nurses to start in September 2018. We spoke with a member of staff on ward 22 (RN) who told us that they felt the nurse staffing was improving and was ‘generally pretty good’. The ward had some new starters and could fill any vacant shifts with bank or agency. The RN told us that there had been a staffing review to determine the staffing levels and usually staff were not now moved from the ward to cover other areas due to the acuity of the patients on this ward. The RN also told us if the ward had short notice staffing absence the site manager would usually ensure cover is provided from another area.

The stroke unit staff told us that there were six RN vacancies in their area however they were managing to fill any vacant shifts with bank or agency nurses. They also told us that they had seen improvement in the number of times they were asked to go and cover other areas.

The trust held operational management meetings four times each day to establish patient flow issues, staffing issues and the capacity and demand on each hospital site. The meetings were attended by staff from a number of disciplines from within the hospitals and included, social workers, pharmacy and transport. Appropriate staff from wards attended to report discharges for the day and escalate staffing or patient flow issues such as delayed discharges.

In addition, a daily staffing meeting took place hosted by a senior nurse on a weekly rota to ensure staffing levels are reviewed across the Trust and short-term plans are put in place. This ensures appropriate escalation and timely requests for additional duties or temporary staffing to respond to patient needs. Managers told us this was a daily challenge and they used a Red, Amber, Green system to prioritise the redeployment of staff.

Staffing levels on wards 22, 24, 25 and 17 were being kept under review due to their significant vacancy rates. Managers told us these areas were prioritised in terms of block booking of bank and agency staff.

Staff on ward 24 told us they were staffed for 24 beds but at that time had 30 beds open, they told us they had additional HCAs to help with staffing but they had 4.84 WTE registered nurse vacancies. The ward used regular agency nurses who had been inducted to the area and had IT access to enable them to access electronic patient records. On the day of our visit the ward had the planned number of RNs on all shifts but was one HCA short on the morning and night shifts.

There were 3.9 wte RN vacancies on the CDU.

Staff on Cath Lab told us they were fully staffed.
Ward 16 staff told us they had four RN vacancies and that they had a new band 4 post coming up to help with this. The ward manager told us she would like to see the reintroduction of the housekeeper role as additional tasks had now fallen to them to cover.

Ward 17 had five RN vacancies but had two new members of staff due to start soon.

We saw that CDU ward 17 and 22 had discharge coordinators/navigators as part of their team, staff valued these roles and they took a lot of pressure off RNs regarding liaison with nursing homes, community care agencies and arranging transport, equipment and care packages for discharge. The feedback was that discharges were better organised when this role was available, for example they could get home Oxygen in four hours when patients were ready for discharge.

We saw another ward that did have a housekeeper in post and staff found the support that this offered was extremely valuable and freed up a lot of time that was better spent delivering care to patients.

We saw that the medical wards supported student nurse placements.

Average fill rates for the medical wards at SGH from February 2018 to April 2018 are given in the table below; however, there are some gaps in data availability. From the data available there was only ward 17 with fill rates of less than 80% for two of the three months reported. Overfill with care staff was explained by managers as being one of the ways they tried to mitigate for a shortfall of RNs.

<table>
<thead>
<tr>
<th>Ward / unit</th>
<th>Inpatient beds</th>
<th>Date</th>
<th>Registered midwives/nurses</th>
<th>Care staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Day</td>
<td>Night</td>
</tr>
<tr>
<td>Coronary care unit (CCU)</td>
<td>Feb 2018</td>
<td>92.70%</td>
<td>98.90%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>Mar 2018</td>
<td>91.30%</td>
<td>100.10%</td>
<td>3.90%</td>
</tr>
<tr>
<td></td>
<td>April 2018</td>
<td>100.60%</td>
<td>100.00%</td>
<td>1.50%</td>
</tr>
<tr>
<td>Clinical decisions unit</td>
<td>Feb 2018</td>
<td>no data available.</td>
<td>no data available.</td>
<td>data available.</td>
</tr>
<tr>
<td></td>
<td>Mar 2018</td>
<td>no data available.</td>
<td>no data available.</td>
<td>data available.</td>
</tr>
<tr>
<td></td>
<td>April 2018</td>
<td>no data available.</td>
<td>no data available.</td>
<td>data available.</td>
</tr>
<tr>
<td>Stroke unit (SSRU)</td>
<td>Feb 2018</td>
<td>85.10%</td>
<td>100.10%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Mar 2018</td>
<td>92.00%</td>
<td>94.10%</td>
<td>.00%</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>----------</td>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td>16</td>
<td>88.90%</td>
<td>100.00%</td>
<td>92.80%</td>
<td>79.10%</td>
</tr>
<tr>
<td>17</td>
<td>96.60%</td>
<td>No data available</td>
<td>95.50%</td>
<td>99.70%</td>
</tr>
<tr>
<td>18</td>
<td>99%</td>
<td>No data available</td>
<td>107.90%</td>
<td>105%</td>
</tr>
<tr>
<td>22</td>
<td>117%</td>
<td>115%</td>
<td>117.30%</td>
<td>117%</td>
</tr>
<tr>
<td>23</td>
<td>97.50%</td>
<td>95.60%</td>
<td>98.70%</td>
<td>108%</td>
</tr>
<tr>
<td>24</td>
<td>148.20%</td>
<td>115%</td>
<td>136.40%</td>
<td>115%</td>
</tr>
</tbody>
</table>

Ward managers told us when staff are moved and this was considered unsafe they would ‘red flag’ this and submit an incident report.

**Vacancy, Turnover and Sickness Rates**

We found that SGH continued to have significant staff vacancies and higher turnover and sickness than the other two hospitals.

From February 2017 to January 2018, the trust reported an annual vacancy rate of 14% for qualified nursing staff in medicine which was higher than the trust target of 6.3%. The vacancy rate at SGH 22% was much higher than the other two hospitals and none of the hospitals met the trust target. The vacancy rate for DPoW was 7% and GDH was 12%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From February 2017 to January 2018, the trust reported an annual turnover rate of 14% for qualified nursing staff in medicine which was higher than the trust target of 9.4%. The turnover rate for each of the hospitals are:

- Diana, Princess of Wales Hospital: 10%
- Scunthorpe General Hospital: 19%
- Goole District Hospital: 15%
None of the hospitals met the trust’s target for turnover rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From January 2017 to December 2017, the trust reported an annual sickness rate of 5% for qualified nursing staff in medicine which was higher than the trust’s target of 4.1%. Sickness rates for the three sites are shown below.

- Diana, Princess of Wales Hospital: 4%
- Scunthorpe General Hospital: 5%
- Goole District Hospital: 1%

Scunthorpe General Hospital was the only site that did not meet the trust’s target for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

From February 2017 to January 2018, the trust reported the following nursing bank and agency staff usage by site:

**Trust level**

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Assistants</td>
<td>-</td>
<td>4,805 (48.1%)</td>
<td>2,029 (20.3%)</td>
<td>9,987</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>7,907 (40.1%)</td>
<td>4,945 (25.1%)</td>
<td>2,796 (14.2%)</td>
<td>19,737</td>
</tr>
</tbody>
</table>

**Scunthorpe General Hospital**

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Assistants</td>
<td>-</td>
<td>2,075 (47.7%)</td>
<td>973 (22.4%)</td>
<td>4,347</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>6,223 (46.9%)</td>
<td>2,857 (21.6%)</td>
<td>1,753 (13.2%)</td>
<td>13,246</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018 there was a total of 19,737 ‘available shifts’ (i.e. unfilled by substantive staff) for qualified nurses 40.1% were filled by agency nurses and 25.1% by hospital bank nurses. This means that 14.2% (2,796) of available qualified nursing shifts remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Pharmacy staffing**

Ward and pharmacy staff raised concerns regarding vacancies in the pharmacy team and apparent problems with retention of staff. The impact of the vacancies was felt to be insufficient cover for some ward areas, for example the CDU pharmacist was often asked to cover the emergency department because of vacancies. Pharmacists also felt there was a risk in the lack of capacity to oversee and screen / audit adequate numbers of over labelled packs and discharge prescriptions. Pharmacists told us there was difficulty attracting and retaining staff. They felt that helping with suitable accommodation, other help for staff and recognition was needed.

**Medical staffing**
The trust has reported their medical staffing numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>55.1</td>
<td>54.8</td>
<td>55.1</td>
<td>55.8</td>
</tr>
<tr>
<td>Goole District Hospital</td>
<td>4.6</td>
<td>5.5</td>
<td>4.4</td>
<td>5.2</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>51.3</td>
<td>52.4</td>
<td>51.1</td>
<td>53.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111.0</strong></td>
<td><strong>112.7</strong></td>
<td><strong>110.6</strong></td>
<td><strong>114.2</strong></td>
</tr>
</tbody>
</table>

In January 2018 the trust had a medical staff fill rate of 101.5%, with an over-establishment of 1.7 more WTE staff in post than the trust planned to provide safe and effective care. Goole District Hospital and Scunthorpe General Hospital both had an over-establishment of medical staff, whilst Diana, Princess of Wales Hospital had a fill rate of 99.6%, with slightly less WTE staff in post than planned.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy, Turnover and Sickness Rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 28% in medicine; the vacancy rate for each of the hospitals is given below;

- Diana, Princess of Wales Hospital: 24%
- Scunthorpe General Hospital: 30%
- Goole District Hospital: 58%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From February 2017 to January 2018, the trust reported a turnover rate of 8% in medicine;

- Diana, Princess of Wales Hospital: 9%
- Scunthorpe General Hospital: 7%
- Goole District Hospital: 0%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From January 2017 to December 2017, the trust reported a sickness rate of 3% in medicine;

- Diana, Princess of Wales Hospital: 2%
- Scunthorpe General Hospital: 3%
- Goole District Hospital: 0%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

From February 2017 to January 2018, the trust reported the following shifts for bank and locum staff:

Trust level
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>159</td>
<td>3,759</td>
<td>40</td>
</tr>
<tr>
<td>Doctor in Training</td>
<td>1,410</td>
<td>8,214</td>
<td>554</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>826</td>
<td>905</td>
<td>67</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>60</td>
<td>1,507</td>
<td>25</td>
</tr>
<tr>
<td>Doctor in Training</td>
<td>662</td>
<td>4,447</td>
<td>427</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>180</td>
<td>368</td>
<td>59</td>
</tr>
</tbody>
</table>

The trust did not provide the total medical and dental shifts available including substantive staff; therefore, bank and locum usage cannot be calculated.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

In October 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 107 whole time equivalent staff working in medicine at Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle Career^</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (SpR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/10/2017 - 31/10/2017)

Medical staff told us that staffing at night and at weekends for the medical service was one Specialist Registrar (SpR), one Senior House Officer (SHO) / middle grade doctor and one Foundation Year One or Two doctor (FY1/2). There was a consultant available on-call and a critical care outreach team available at night. Junior medical staff told us that the workload could feel burdensome at night and weekends as the SpR was usually tied up seeing the sickest patients and was also the duty registrar for stroke. The SHO / middle grade doctor would see new admissions. The FY1/2 had to do all reviews and tasks on all of the medical wards and was also expected to help with clerking patients on CDU. At times this made the FY1/2 doctors feel unsupported and vulnerable. Staff on the stroke unit told us they felt the medical cover was generally adequate for the unit but they sometimes worried the on-call registrar arrangements could be potentially unsafe, even though there had never been an incident when the SpR had needed to be in two places.
Junior doctors felt that the medical cover at night was insufficient and an additional SHO/ middle grade doctor was needed to support workload and time for teaching / learning. They also told us that ‘technically people are available but contacting them is another matter.’

We were aware that the local deanery was not placing Cardiology FY1 and FY2 doctors at the trust as there had been a lack of support and teaching available due to consultant pressures. The trust had recently appointed a new clinical tutor who would look at this as part of their role.

There was teaching for junior doctors on the medical grand round, weekly and weekly lunchtime sessions for FY1. Juniors felt the quality of the teaching was very good.

Doctors told us there were a number of long-term locums in post (at middle grade level) which provided some continuity of cover for services, patients and support for junior doctors. They told us there was a rota coordinator responsible for filling gaps in the medical rota and these were usually filled by SpRs.

Junior doctors told us that the numbers of outliers compounded the vacancies this could increases workload to approximately 125%. They said that this impacted on the service and care provided to patients and the teaching available to trainees.

**Records**

The Trust was going through a transition from paper records to the Acute Electronic Patient Record in WebV which meant that both were required to be used.

We did not have any concerns about the security of records on most wards we visited. However, we saw that the notes trolley on CCU was unlocked and the key for the trolley on ward 22 was left in the top when the trolley was unattended. We saw an isolated incident of a set of records being left unattended when a member of staff went to help move a patient behind a set of curtains.

We looked at 25 sets of medical records belonging to medical patients at SGH and found that all had a clearly documented history and plan of care. However, there were patients (four on CCU/ ward 24 and three medical outliers ward 28) where it was not clearly documented whether they had been reviewed within 14 hours, of admission, by a consultant or whether they had regular consultant reviews. The patients on CCU/ ward 24 appeared to have had daily reviews by other medical staff. For the patients on ward 28 it was difficult to ascertain a clear chronology for two patients, and there were some gaps, there was a clear three-day gap for one patient. All records were signed and dated but time was not always recorded, there was good evidence of multidisciplinary input but it was not always easy to identify a patient’s DNACPR status as documentation was not always held in the same place. Eight of the 13 records we saw where instructions regarding resuscitation were present were not fully completed.

We reviewed a further seven sets of records on our unannounced visit to wards, 22, 24 and the stroke unit to look specifically at documentation of ceiling of care and found that this was only clear in three of the sets of notes and only one set had this recorded in the designated part of the clerking proforma.

A trust-wide audit of adult nursing documentation across all three hospitals in April 2018 had given the trust moderate assurance. This was an improvement on the previous audit which only gave limited assurance. Some of the areas that needed further improvement were identifiers on every page such as patient name, date of birth, NHS number and consultant. Discharge plans and checklists were also an area for improvement, as was the use of a pain chart and the documentation of evaluation of analgesia effectiveness. The action plan had not yet been developed following this audit as the report was still in draft stage.
A trust-wide documentation audit of medical records in May 2018 gave limited assurance similar to previous years. Like the nursing audit it showed that recording of demographic/patient identifiers needed to be improved. Documentation of initial assessment using the CDU/AMU clerking document was generally good, however it was also evident that documentation of discussions with patients and or carers about their care needed to be improved and gaps in care were also highlighted by the audit. An action plan had been developed to address the gaps found by the audit.

**Medicines**

Inpatients on the medical, surgery and paediatric wards received a Medicines Reconciliation Service within 24 hours of admission and a clinical review by a pharmacist (with a prescribing qualification when available). All new medicines were reviewed by a pharmacist but pharmacy do not currently support discharge. There were two medicines management nurses to support the safe use of medicines trust wide.

The Frail Elderly Assessment Support Team (FEAST) team could contact a designated pharmacist if they needed medicines not stocked on the unit. Staff arranged changes to dosette boxes (pill organisers) by contacting the patients’ GP practice.

We checked that medicines, including controlled drugs were stored safely and securely on most wards however we found that discharge medicines were not locked away in the discharge lounge.

Staff on the Stroke unit, CDU, the endoscopy unit and ward 18 told us that they received a pharmacy visit every day to perform medicines reconciliation and to manage stocks. Staff on the stroke and endoscopy units used two nurses to check over labelled packs for discharge medicines to ensure there were no transcribing or labelling issues. We were told that a second check was not always performed on ward 18. Nurses told us that medicine errors were incident reported but felt that labelling transcription errors on discharge medicines may not always be reported. Pharmacists also felt that this type of incident may be under-reported.

On one ward there was a lessons learnt board that included learning from serious incidents involving medicines. The charge nurse told us that they did not receive incident reports concerning medicine errors, although serious incidents were fed back for dissemination to all staff. Staff were aware of recent medicine serious incidents including a dispensing error from a community pharmacy.

We saw evidence on all the wards we visited that nurses checked controlled drugs (CDs) weekly in line with policy and pharmacy staff carried out a 3-monthly check. There were separate CD registers for patients own medicines. Staff in the endoscopy unit checked CD stock at the end of every list. However, we found some issues with staff not always signing for receipt of CD stock on wards 22 and the stroke unit. We found five occasions on ward 23 where withdrawals had not been double signed.

We checked the medicines fridges and saw daily minimum and maximum temperature checks were completed on all wards and in most cases action taken and recorded when readings were outside of the 2-8°C range. However, we saw a number of recordings outside the recommended range on the stroke unit but there were no notes of actions taken. We saw that domestic fridges were also checked daily but there was little documented regarding actions taken when out of range.

Patient Group Directions were in use on the endoscopy unit for fleet enemas and Entonox, these were up to date and accessible on the intranet. Endoscopy staff were going to pilot the nurse in
Patients wanting to self-administer medicines had a risk assessment performed before this was initiated, however we saw little evidence of patients self-administering. Nurses we spoke to told us it was mainly diabetic patients who self-administered their own medicines. One patient on CCU had been assessed for self-administration of medicines.

On the stroke unit we found one incidence of liquid medicine not having a date of opening labelled, however we saw that ‘opened on’ date was recorded on liquid medicine on ward 18. We found one expired chemotherapy medicine on ward 18.

We found, on the stroke unit, ward 18 and the endoscopy unit that medicine charts were generally completed well with; VTE assessments, allergy status and whether medicines reconciliation had been completed. However, start and stop dates for antibiotics was not always completed. Four out of four charts reviewed on the endoscopy unit, three out of five on ward 18 and one out of one on the stroke unit did not have a review or stop date for antibiotics.

We reviewed another sample of 14 medicine cards across all medical wards and found that all medicines were prescribed appropriately with start and stop dates where relevant, there were three drug charts where patient weight was not documented, two VTE assessments were missing and three out of nine patients receiving oxygen either did not this have prescribed or target saturations were not recorded. We noticed two patients' records had medicine omissions, when we asked about them; one medicine was being withheld due to a patient’s abnormal blood results but this was not recorded on the medicine chart. There was no reason known or documented for the second omission so the nurse in charge was asked to report this as an incident.

Part of the adult nursing audit dashboard asked whether there was; more than two omitted doses of one or more medicines, was the reason for omission documented and was appropriate action taken regarding the omitted dose. Cumulative results for the period from January 2017 to November 2017 showed that where omissions were noted the reasons for this were documented in 97.5% of cases and appropriate action was taken in 98.6% of cases.

Incidents

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2017 to January 2018, the trust reported no incidents classified as never events for medicine.

Source: NHS Improvement - STEIS (01/02/2017 - 31/01/2018)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from March 2017 to February 2018. This is almost double the amount covered by the period reported at the last inspection from August 2015 to August 2016 (11).

A breakdown of the incident types is shown below:

- Six medication incidents meeting SI criteria (30% of total serious incidents).
• Four treatment delays meeting SI criteria (20% of total serious incidents)
• Four pressure ulcers meeting SI criteria (20% of total serious incidents)
• Two surgical/invasive procedure incidents meeting SI criteria (10% of total serious incidents)
• Two slips/trips/falls meeting SI criteria (10% of total serious incidents)
• One pending review (5% of total serious incidents)
• One commissioning incident meeting SI criteria (5% of total serious incidents)

12 of the 20 incidents occurred at Scunthorpe General Hospital and eight at Diana, Princess of Wales Hospital. No serious incidents were reported at Goole District Hospital during the period.

A breakdown of the 12 incidents occurring at Scunthorpe General Hospital below:

• Three medication incidents meeting SI criteria
• Three pressure ulcers meeting SI criteria
• Three treatment delays meeting SI criteria
• Two surgical/invasive procedure incidents meeting SI
• One slips/trips/falls meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Data provided by the trust showed 2,650 incidents were reported by staff on the medical wards at SGH from January 2017 to April 2018. However, there was no breakdown relating to the degree of harm.

Staff we spoke with were aware of the reporting system and could tell us when they would report an incident. Some of the more junior staff told us they would report an incident to the nurse in charge. Staff we spoke with about incident reporting felt that the reporting culture, on the wards, was positive. However, some nursing and pharmacy staff felt there may be an under-reporting of medicine incidents such as labelling errors for discharge medicines and possibly omitted medicines/missed doses. On one of the medicine cards we looked at we found there was no reason known or documented for a medicine omission, this was highlighted to the nurse in charge that it needed to be reported as an incident.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Most staff could describe the process they used in relation to the duty of candour and gave examples such as after a fall with harm or when a patient developed avoidable pressure damage. We saw ‘lessons of the week’ posters displayed for staff in CDU these included missed medications due to a delay in ordering and the actions taken and those staff needed to take to prevent similar incidents occurring.

Ward 22 staff told us they had a safety huddle after handover to discuss incidents, learning and action. The ward manager told us information bullet points were emailed to all staff on the ward.

One of the doctors told us of a recent SI that had been reported as potentially avoidable death. Managers told us there was work ongoing to improve the mortality review process and more closely align this with the trust’s SI process. As part of the mortality review programme, where a reviewer felt care had been poor or concerning, they would refer for a second review.

We reviewed minutes from the respiratory and gastroenterology department’s mortality and morbidity meetings, which showed discussion and learning points from the review of mortality cases and pathway audit. There was evidence of action to improve the services and identification
of factors which may affect mortality outcomes such as, for gastroenterology, length of stay in the emergency department, getting the patients into the right bed and lack of alcohol liaison services. There was also the recognition of things that had made a difference in other services such as having a specialist, respiratory in reach nurse to ensure patients were on the correct pathways and had appropriate care plans. The respiratory minutes highlighted similar issues such as length of stay in the emergency department and the number of deaths outside of the respiratory ward.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 124 new pressure ulcers, 26 falls with harm and 15 new catheter urinary tract infections from December 2016 to December 2017 for medical services.

From June 2017 to May 2018 we saw that the percentage harm free care for SGH ranged between 81% and 91%. There were seven dips in performance over the year of below 70%, three of these were on ward 16 (August to October 2017), two in CCU September 2017 and January 2018, one on ward 18 April 2018 and one on ward 24 October 2018.

We saw data such as the number of pressure ulcers, catheter associated urinary infections and falls displayed on medicine wards, for January to March 2018.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Northern Lincolnshire and Goole NHS Foundation Trust**

![Graph showing prevalence rate of pressure ulcers and falls](image)

<table>
<thead>
<tr>
<th>Total Pressure ulcers (124)</th>
<th>Total Falls 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>1.2</td>
</tr>
<tr>
<td>3.0</td>
<td>0.8</td>
</tr>
<tr>
<td>2.0</td>
<td>0.4</td>
</tr>
<tr>
<td>1.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Is the service effective?

Evidence-based care and treatment

Staff had access to trust policies via the trust intranet hub. Patient records from both wards showed staff used a number of standardised care pathways to plan care for patients. We looked at some of the trust’s clinical protocols and patient pathways used for patients on medical wards; this included the trust’s stroke, non-invasive ventilation and skin integrity pathways. We found that these followed nationally recognised best practice and current evidence base. The pathways were clear and easy to follow.

The FEAST team showed us the results from their audit (January 2018) which showed that out of 111 patients 97 (87.4%) were successfully assessed / treated and returned home. The audit results showed that eight patients were admitted and 6% of all patients seen were inappropriate for assessment by the team. The results for February 2018 were similarly successful with 84% of patients seen able to return home. The team also provided follow up phone calls to patients to evaluate the patients’ situation at home and provide further advice or liaison if needed, 7-days after being seen on the ward.

The trust took part in several National and Local Audits. There was a monthly programme of nursing indicators for adult in patient wards which included physiological observations, completion of risk assessments and other patient safety indicators. Results were reported as part of the nursing audit dashboard and identified areas for improvement or where support was needed. One of the quality matrons told us it was hoped to develop further audits for non-clinical transfers and delayed discharges, within the next six to 12 months.

Nutrition and hydration

The August 2017 PLACE audit gave food a score of 77%, which was worse than the national average of 90%.

We saw that food and drinks were left within reach of patients and patients reported that the food offered was hot and presented well. They told us the food was generally appetising and there was a good choice. Patients told us that water jugs were changed routinely twice a day and nurse would change them or re-fill them if asked. Hot drinks were offered with meals, mid-morning, mid-afternoon and on an evening.

Protected mealtimes were promoted on most of the wards we visited. We saw information about this displayed on some of the wards.

Part of the adult nursing audit dashboard covered a number of food and hydration indicators from risk assessments to completion of food and fluid records. Cumulative results for the period from
January 2017 to November 2017 showed that completion of risk assessments was 96%. Completion of fluid and food charts was 95%.

Where necessary we saw that patients, who were at risk of malnutrition were referred for specialist advice from dieticians.

Most patients told us that they enjoyed the food on the wards. They said that the food was hot, they had enough to eat, there was plenty of choice and they were supported when necessary. Patients also said they had plenty of drinks.

**Pain relief**

All patients we spoke with told us they received pain relief in a timely manner. We saw a patient complain of headache on the stroke ward, staff responded immediately to provide analgesia and check clinical observations.

We saw that staff checked on the patient’s level of pain routinely as part of comfort rounds and that evaluation of pain was documented in patients’ nursing records.

Trust staff used the Abbey pain scale for patients with dementia and could access specialist nurses for support if needed to help assess pain for patients with learning disability or dementia.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From November 2016 to October 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in medical oncology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a lower than expected risk of readmission for non-elective admissions

**Elective Admissions – Trust Level**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

**Non-Elective Admissions – Trust Level**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: HES - Readmissions (01/11/2016 - 31/10/2017))

**Scunthorpe General Hospital**

From November 2016 to October 2017, patients at Scunthorpe General Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in medical oncology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions

**Elective Admissions - Scunthorpe General Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

### Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest the audit, April to June 2017.

### Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>2) Stroke unit¹</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>D</td>
<td>C</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>5) Occupational therapy</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>6) Physiotherapy</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>7) Speech and Language therapy</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>8) MDT working</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>9) Standards by discharge</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>10) Discharge processes</td>
<td>B</td>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team-centred SSNAP level (after adjustments)</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team-centred Total KI level</td>
<td>A</td>
<td>B</td>
</tr>
</tbody>
</table>

### Overall scores

<table>
<thead>
<tr>
<th>Overall scores</th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>
Heart Failure Audit

In-hospital Care Scores

Results for Scunthorpe General Hospital in the 2017 Heart Failure Audit (using data gathered between April 2015 and March 2016) were worse than the England and Wales average for three of the four standards relating to in-hospital care and similar for the remaining one.

Discharge Scores

Results for Scunthorpe General Hospital were better than the England and Wales average for five of the nine standards relating to discharge and worse for four.
National Diabetes Inpatient Audit 2017
The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 48 in-patients with diabetes at Scunthorpe General Hospital, 90.3% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile four.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)
All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 30.1% of nSTEMI patients were admitted to a cardiac unit or ward at Scunthorpe General Hospital and 79.0% were seen by a cardiologist or member of the team compared to an England average of 55.8% and 92.6%.
The proportion of nSTEMI patients who were referred for or had angiography at Scunthorpe General Hospital was 74.1% compared to an England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit 2017
The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 84.7%, which did not meet the audit minimum standard of 90%. The 2016 figure was 67.4%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 13.7%; this was within the expected range when compared to the national average of 17.5%. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 67.2%; this was within the expected range when compared to the national average of 68.0%. The national aspirational standard was 70%. The 2016 figure was not significantly different from the national level.

The one-year relative survival rate for the trust was 32.6% which was within the expected range when compared to the national rate of 37.0%. The 2016 figure was not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017
Scunthorpe General Hospital:

The trust has a multi-disciplinary working group for falls prevention where data on falls is discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 56.5%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 8.3%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 56%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with an appropriate mobility aid in reach (if applicable) was 40%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Mortality Outliers
The trust currently has two active mortality outliers. One is under consideration by the outliers’ panel (heart valve disorders from September 2017) and one case where action plans are being followed up by local inspection team (septicaemia (except in labour) from September 2016).
Competent staff

Appraisal rates
From April 2017 to January 2018; 63.4% of staff within medicine at the trust had received an appraisal compared to a trust target of 95%. Compliance at SGH was around 63% which was also similar to the previous year’s achievement.

A split by site and staff group can be seen in the graph below:

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>22</td>
<td>30</td>
<td>73.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>96</td>
<td>140</td>
<td>68.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>104</td>
<td>172</td>
<td>60.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>32</td>
<td>62</td>
<td>51.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>2</td>
<td>7</td>
<td>28.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

Due to delays in IT systems, ward managers felt that appraisal rates were higher than the downloaded report. Most staff we spoke with told us they had an up to date appraisal.

During the inspection we saw data on CCU that indicated that 90% of nursing staff had received an appraisal within the last 12 months. Clinical supervision was also provided for nurses in this area and we saw that 75% of nurses had received this. The appraisal rate for CDU was 68%, ward 23 was 71%, ward 22 told us there were only five appraisals outstanding but one staff member was on long-term sick. We saw that 75% of staff on ward 23 had received clinical supervision.

Wards that were particularly poor for appraisals, at April 2018, were PIU - 13%, Cath Lab - 27% and ward 18 - 37%. It also appeared that most of the specialist nurses had not had an appraisal in the last 12 months.

One staff member told us how they were supported with a return to work programme and were booked onto a ‘care camp’ to access all mandatory training in one go.

A healthcare assistant (HCA) who had joined the trust less than a year ago told us they had lots of initial training and support to learn new skills and become competent in their role.

Registered nurses told us that there was little support (no funding) for external courses but good access to internal training and development.
Staff working in oncology day care unit had received training to enable them to administer chemotherapy.

We saw that staff on the respiratory ward had received training in tracheostomy care and NIV. There was also training for staff in the use of new monitors. The respiratory consultants also provided learning opportunities and updates for staff on the ward.

There were clinical skills educators employed by the trust to provide education and training to staff in the clinical / ward areas. Feedback from newly qualified nurses regarding training and support from the clinical skills team was excellent. We observed staff receiving clinical skills training for insertion and management of naso-gastric tubes on the stroke unit. The training was practical, informative and competency based. There was plenty of opportunity for the learner to ask questions.

Newly recruited staff and student nurses told us they were supported by mentors. Newly qualified nurses said they had a preceptorship period and a supernumerary period when they first joined the trust. Staff told us they were competency assessed during their preceptorship period.

Staff told us the trust provided information and support for NMC revalidation. Doctors we spoke with had received appraisals and told us there were no issues with revalidation.

**Multidisciplinary working**

Staff we spoke with told us that they had positive and supportive relationships with the multidisciplinary team (MDT) for example, medical staff, specialist nurses, therapists, dieticians, social care workers, mental health liaison and community teams.

We saw that specialist nurses such as diabetes and respiratory nurses visited patients on the ward and we saw evidence of their input to plans of care and treatment documented in patient records. We saw evidence of the effectiveness of the FEAST team, working both in the hospital and with community-based partner services and organisations, to provide the most appropriate care for frail elderly patients.

Haematology / oncology staff told us they had good support from the MacMillan team, physiotherapists who were based on the ward and their consultants.

Multidisciplinary input and family involvement in patients on the stroke pathway was very evident in the pathways we looked at.

We saw that ward and board rounds were held on the wards to discuss patients’ needs and to plan for discharge. We saw that the board rounds were largely made up of medical staff. On ward 17 and 22 we saw that the morning hand over was multi-disciplinary and included occupational therapists, physiotherapist, doctors a social worker and nursing staff.

We observed a medical handover at shift change, this was clear and well-structured with good consultant involvement, patients who had failed discharges or readmissions as well as those who needed escalation for senior review were highlighted. Patients NEWS and sepsis risks were also discussed and the consultant was informed of a patient who was very distressed and wished to make a complaint. There was good attendance at this meeting by medical and nursing staff from relevant areas including ambulatory care and the frail elderly assessment team.

The nursing handover on the CDU was clear and well-structured and gave appropriate information regarding patients’ condition and risk assessments, any elevated warning scores, plan for admission or discharge and any outstanding treatment, tasks or test results. The nursing handover on ward 22 also included information about people’s individual needs, including mental health, learning disability and long-term conditions.
Medical patients were discussed at MDT meetings for cancer and other specialist services such as Neurology. Cancer MDT’s took place weekly and were cross site for each tumour site. Core membership included Consultants, Radiologists, Oncology, Clinical Nurse Specialists, Allied Health Professionals and MDT Coordinators. Where network links existed to other trusts and organisations, the MDT took place at the lead organisation with video links to NLaG.

Staff knew how to refer to mental health and alcohol teams and understood that patients needed to be medically fit before referral to the alcohol team. Staff reported good support from the alcohol team and the mental health team but felt there were gaps with support from the crisis team who sometimes only offered telephone assessments when staff felt patients needed to be seen.

**Seven-day services**

The general medical model for the Trust was that Monday - Friday 8am to 5pm, acute care physicians provided cover and support for emergencies, the medical assessment units and caring for any new admissions through the emergency department and direct to ward.

Monday - Friday 5pm to 8am, a general physician was on call, with physical presence until 8 – 9 pm, depending on need. After this time, the physician was on call from home.

Weekend arrangements were 8am to 8pm general physician led on site and then continued to support off site, on call until the following morning. This provided cover and support for emergencies, the medical assessment units and caring for any new admissions through the emergency department and direct to ward.

In addition, at both sites, on weekends and bank holidays, a second medical consultant was available and responsible for discharging and providing routine support to ambulatory care and general support.

Additionally, on a Monday and a Friday, at SGH, an additional consultant was physically present to support admissions/discharges.

We spoke with a registrar and a junior doctor (FY2) who said that there were no daily consultant ward rounds as these did not take place at weekends. We were told that a handover of care took place on a Friday. A registrar would then review any poorly patients over the weekend whilst the junior doctors completed the routine tasks such as blood results.

CCU Staff told us that consultant ward rounds tended to correspond with admission and on-call days and did not happen every day. Staff on ward 24 told us that the consultant ward round for endocrinology patients was only twice a week, cardiology consultant rounds were unpredictable and on weekends only patients for discharge were routinely seen by a consultant. Staff told us that if they were worried about a patient they would ask the duty registrar or consultant covering discharges to review them. Staff commented that it was sometimes difficult to contact a consultant but if they escalated a poorly patient for review they would be reviewed quickly by a member of the medical team. Junior doctors on the cardiology ward told us that they saw all patients every day and patients were reviewed by a consultant twice a week on ward rounds. The SpR carried out one further ward round each week.

We were told that a consultant completed a ward round on the Hyper Acute Stroke Unit (HASU) everyday including Saturdays and Sundays. On the general stroke ward there was a consultant ward round twice a week and a registrar ward round three days each week Monday to Friday.

A trust wide audit of Clinical Standard 2 - Time to 1st Consultant Review in September 2017 showed that for the trust overall; the proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was 69% for weekdays and 68% at a weekend. A breakdown of medical specialities is detailed in the table below.
<table>
<thead>
<tr>
<th>Admitting specialty</th>
<th>Weekday</th>
<th></th>
<th>Weekend</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Within 14 hours</td>
<td>Outside of 14 hours</td>
<td>Total</td>
<td>Within 14 hours</td>
<td>Outside of 14 hours</td>
</tr>
<tr>
<td>Acute Internal Medicine</td>
<td>52</td>
<td>5</td>
<td>57</td>
<td>91%</td>
<td>20</td>
</tr>
<tr>
<td>Cardiology</td>
<td>7</td>
<td></td>
<td>7</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Diabetes and Endocrinology</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>1</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>75%</td>
<td>3</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>9</td>
<td>1</td>
<td>10</td>
<td>90%</td>
<td>2</td>
</tr>
<tr>
<td>Oncology</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>67%</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory Medicine (Thoracic Medicine)</td>
<td>7</td>
<td></td>
<td>7</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Stroke Medicine</td>
<td>2</td>
<td></td>
<td>2</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Trust wide audits of time from admission to patient made aware of diagnosis, management plan and prognosis by day of the week was the same whether this was a weekday or at a weekend. Audit of documentation of the reason why the patient (and where appropriate families / carers) were not involved in discussions about the initial review within 48 hours of admission showed poor compliance but again showed no difference between weekend or weekday.

Staff told us about the weekend discharge team which was multi-disciplinary and commented that clear plans were left in place. The discharge team and consultant generally saw those patients ready for discharge only.

Staff in some areas told us that a consultant of the week model had been trialled and that this seemed to have worked quite well but thought this had stopped due to consultants ending up with patients from other specialities.

There was seven-day cover (8am – 8pm) of physiotherapy on wards 2 and 17 as part of the FEAST team and was available to the other wards via on-call arrangements at weekends and at night.

A pharmacy service is provided in SGH and DPOWH from 8am until 6pm on Monday to Friday and between 9am and 2pm at weekends and on Bank Holidays. An on-call pharmacy service is provided to each main site outside of these hours.

**Health promotion**

We saw lots of health promotion information on the wards and around the hospital. For example, the information on the stroke unit included stopping smoking, local alcohol services, carers support and falls prevention. There was also a big display by the stroke association who visited the ward weekly to bring information and talk to patients as requested.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLS). DoLS can only be used if the person will be deprived of their liberty in a care home or hospital.

We looked at the trust's policies for consent and mental capacity act, including DoLS. We found that these were in date and contained appropriate references to legislation such as the mental capacity act, equality and diversity and the human rights act.

We observed staff seeking verbal consent and patients told us that staff always asked permission before providing care and treatment.

Staff could describe the consent process in PIU and how ‘best interest’ decisions were made when necessary.

We found that staff considered life choices as part of capacity assessments and best interest decisions and sought advice from other members of the ward MDT as well as the safeguarding and learning disability (LD) specialist nurses when difficult decisions needed to be made.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that Mental Capacity Act (MCA) training had been completed by 75% of staff and Deprivation of Liberty training had also been completed by 77% of staff within medicine at May 2018. However, medical staff compliance with MCA and DoLS training was extremely poor at SGH with the exception of dermatology and stroke services who had 100% compliance, the other services had 0% to 38% compliance for MCA training and 0% to 75% for DoLS training.

The trust safeguarding lead told us that trust wide as of end of April: Mental Capacity Act (MCA) training was at 74%; DoLS training Level 1 was 77% and Level 2 was 56%. The trust was currently reviewing which staff need level 2 training for DoLS. MCA and DoLS training was delivered together with a focus on consent to treatment. Best Interest assessors within the trust had separate additional training.

The trust Safeguarding lead identified Level 3 training as a priority for the trust, together with making sure DoLS training is embedded.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 44% which was better than the England average of 25% from December 2016 to November 2017.

**Friends and family test – Response rate between 01/12/2016 to 30/11/2017 by site.**
### Friends and family test – Medicine wards response (% recommended) - Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dec-16</td>
</tr>
<tr>
<td>CCU</td>
<td>502</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td>Clinical Decisions Unit</td>
<td>106</td>
<td>17%</td>
<td>100%</td>
</tr>
<tr>
<td>Planned Investigations Unit</td>
<td>145</td>
<td>32%</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke Unit (SSRU)</td>
<td>180</td>
<td>21%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 16</td>
<td>190</td>
<td>28%</td>
<td>81%</td>
</tr>
<tr>
<td>Ward 17</td>
<td>154</td>
<td>16%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 18</td>
<td>246</td>
<td>54%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 22</td>
<td>229</td>
<td>34%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 23</td>
<td>491</td>
<td>46%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 24</td>
<td>525</td>
<td>58%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

We spoke with 27 patients and relatives who had received care from the medical wards and departments and the feedback about staff and treatment was mostly very positive.

We spoke with six patients on ward 17 who all described staff as; friendly, caring and kind. They told us call bells were answered quickly and privacy and dignity was maintained.

We observed staff from all roles speaking to patients in a caring and courteous manner, displaying a genuine desire to help.

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We saw that staff had implemented protected mealtimes and displayed patient experience feedback for all to see. However, there did not seem to be protected mealtimes on the CDU.

Patients on CDU said it took a long time for staff to answer buzzers and felt they were ignored if it was handover time. However, staff were good when they came.

There was ‘you said, we did’ information at the entrance of the CDU.

Oncology/ haematology patients were often well-known to the ward staff and staff were aware that patients could become upset if they needed to be admitted to a different ward because of bed pressures. Staff in this area tried hard to minimise any movement of patients and to facilitate direct admission.

We saw staff being kind to patients and happy, courteous and respectful interactions. We also saw staff particularly on wards 16 and 17 were kind to each other and were proactive in offering help and support to colleagues.

The stroke unit had a calm, friendly atmosphere, patient feedback was good and patients looked well-cared for.

On most occasions on all wards call bells were answered quickly.

We saw staff treating patients with respect and preserving their dignity, sometimes in very difficult circumstances. Patients felt staff were approachable and they could “have a laugh with them”.

We saw examples of where staff had gone out of their way to provide support to their patients. For example, we saw that staff had arranged for a service to be arranged on the ward for a patient who was not well enough to leave hospital to attend her son’s funeral. The service was held at the same time as the funeral was taking place.

We saw therapists undertaking assessments in a supportive and encouraging way.

**Emotional support**

One patient told us that nurses gave them reassurance when they became anxious. One relative told us their loved one had been to the hospital three times in 10 days due to recurrent delirium with an infection but the nurses were great supporting them emotionally and providing them drinks as they were there all night.

We saw that staff in one clinical area were giving and receiving support following the death of a long-term patient.

Nurses worked with the Macmillan team to provide emotional support to patients with cancer.

**Understanding and involvement of patients and those close to them**

Patients on ward 17 told us that doctors encouraged them to ask questions if they didn’t understand and that they were told what they wanted to know.

We saw that shift leaders on ward 17 wore a red name badge so they were easily identifiable to patients and relatives.

Patients on Cath Lab told us everything was explained in way they could understand.
We heard patients being given clear instructions in a caring manner and saw examples of where passwords had been set up for relatives to be given information over the phone (where patient consent had been given).

We spoke with patients who had a good understanding and involvement in their plan of care and step-down arrangements from high observation to level one care.

Staff on ward 18 felt they delivered good end of life care but felt there were areas they could improve and were trying to make improvements in areas such as facilitating earlier end of life care discussions with the medical team regarding choices about resuscitation.

Is the service responsive?

Service delivery to meet the needs of local people

Average length of stay

Trust Level
From December 2016 to November 2017 the average length of stay for medical elective patients at the trust was 4.8 days, which is lower than the England average of 5.8 days. For medical non-elective patients, the average length of stay was 7.1 days, which is higher than the England average of 6.5 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in medical oncology is higher than the England average.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.
Non-Elective Average Length of Stay – Trust Level

Scunthorpe General Hospital
From December 2016 to November 2017 the average length of stay for medical elective patients at Scunthorpe General Hospital was 3.8 days, which is lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 6.1 days, which is lower than England average of 6.5 days.

Average length of stay for elective specialties:
- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in medical oncology is higher than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.

Non-Elective Average Length of Stay - Scunthorpe General Hospital

Average length of stay for non-elective specialties:
- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.
Meeting people’s individual needs

Admission forms did not cater for the recording of transgender or civil partnerships and we found that the religion section was rarely completed.

The stroke unit had a kitchen and gym where patients could undergo tailored therapy sessions and assessments prior to discharge. We saw therapists asking patients about varying their therapy sessions if they were finding them too tiring. We saw that patients on the stroke ward were dressed to maintain their dignity and individuality.

Patients with dementia or a learning disability could be flagged on the trust electronic system using a specific icon, the icons could also identify if the patient had a person-centred care plan document 'My Life' for dementia patients or a ‘traffic light passport’, for people with a learning disability. We saw staff used 'My Life' documentation to facilitate person-centred care for patients with dementia and encouraged carers to be involved in planning and giving care where appropriate.

The trust had a full time Quality Matron who was the strategic lead for dementia and learning disabilities across the trust and there was a full time Dementia Specialist Nurse and a part-time Learning Disability Specialist Nurse working at the hospital.

The Dementia Clinical Nurse Specialist was available to review patients in terms of nutrition and hydration, pressure areas, pain assessment (use of Abbey pain scale) and falls risks. They also reviewed medication and the use of sedatives and anti-psychotics. They supported staff with capacity assessments, best interest decisions and DoLS.

The Learning Disability Liaison Nurse (LDLN) reviewed inpatients on the ward and discussed with them and their carers about their understanding of why they were in hospital and if any reasonable adjustments were needed to make the patient’s stay as comfortable as possible. The LDLN could complete a reasonable adjustment care plan and a hospital passport for any patient without one. They would also support staff with ensuring capacity assessments and best interest decisions were made and documented.

The specialist nurses were notified of all admissions through the IT system and could be contacted by phone/bleep if a ward needed immediate advice or wanted to request support. There was a prompt on the nursing admission for documentation for staff to contact the learning disability (LD) specialist nurse when an LD patient was admitted.

There were good examples of where staff had worked well with patients with a learning disability and their families to ensure their stay on the ward was comfortable and minimised any distress. On ward 17 we observed staff had worked hard to provide continuity of staff and maintenance of a patient’s usual routines to minimise their distress while in hospital. Ward 16 staff promoted
‘dementia friendly’ care they used the ‘My Life Booklet’ and were in the process of developing a
dementia room. Rummage/activity/reminiscence boxes and twiddle muffs were available for
patients with dementia. The CDU had ordered a dementia friendly clock for their day room.

The hospital staff also had access to a mental health liaison team when they needed more
specialist assessment and input into care and treatment for patients with dementia, a learning
disability or mental health needs.

The quality matron for dementia and learning disability told us that dementia training was
mandatory for all staff who come in to contact with patients. The training target for this training was
85% at tier 1 and tier 2 the achievement was 86% and 71% respectively at trust level. They told us
that every ward has a dementia champion who attends a quarterly meeting led by dementia
specialist nurse.

We saw that adjustments had been made to meet the care needs of a bariatric (larger) patient and
there was a multi-disciplinary approach to moving and handling for this patient. Staff told us that
there had been some occasions when they hadn’t been able to move the patient due to insufficient
staff at that point in time. This was being taken very seriously and an incident was reported when
this had happened.

The trust provided the results of the 2017 patient led assessment of the care environment
(PLACE) assessment. Patients gave this hospital an overall score of 60% for dementia care, this
is improved from the previous score of 54% but is worse than the 2017 national average (76%).

The dementia lead told us that as the trust does not have dementia specific wards, this made
environmental changes difficult. However, all wards now had plain curtains and dementia friendly
signage. They told us that there was board commitment to improve the wards to dementia friendly
environments when refurbishment takes place.

There was a chapel for patient and relative use that was also used to offer mindfulness sessions
on a drop-in basis. There was little information in the chapel for multiple faiths. A bereavement
service and multi faith chaplaincy services were available on site and staff could access these for
patients.

The Trust had the facilities in place to access interpreter services over the telephone. Staff were
also able to request face-to-face interpreters. The service providers could translate documents into
different languages when necessary. British Sign Language Interpretation was also available for
patients who were deaf or hard of hearing. We saw communication aids in place for people who
were hard of hearing. Staff we spoke with told us they could access support from interpreters
when needed and information was available on the trust intranet.

Patients told us they did not have access to Wi-Fi on the ward and that TV although free on a
morning was expensive after 12 noon. One patient commented that receiving calls on the hospital
phone was also very expensive.

One patient on ward 24 was complementary of individual staff but felt it was difficult to know who
was in charge on the ward and had encountered difficulty speaking to the matron when they had
requested to do so about an issue with transfer to another hospital. The transport had not arrived
to transport them to the tertiary centre at Hull which had meant they lost their bed and had to wait
again.

The FEAST team were very aware of the needs and wants of their patients and discussed with
patients, family and carers future care needs and advanced care plans. They ensured support was
provided to families and carers / care homes to enable patients to be discharged and cared for at
home.
Access and flow

At this hospital elective patients were admitted directly to the wards or departments and non-elective patients were admitted through the emergency department or the CDU. The clinical decisions unit had 22 beds and patients were assessed and stabilised here before being transferred to a ward.

The FEAST team were based on ward 2 of the hospital where elderly patients were assessed and treated by a multidisciplinary team. This team had established links with acute and community services to initiate speedy treatment and care packages in the patients’ home to be able to prevent inappropriate admissions and provide more appropriate care in the patient’s own home. The patients could return to the ward for day care treatments or further tests as necessary. Staff could admit patients via the site manager if necessary. The team received patients from emergency department CDU or via GP referral if agreed by the medical team.

The ambulatory care unit was open from 8am until 8pm everyday but only had dedicated medical cover Monday to Friday. The unit had initiated an outreach service for treatments which could be given at home such as intravenous antibiotics and certain nebulised medicines. Staff felt that both the unit and the outreach service had greater scope and needed promoting and developing further. Staff actively sought appropriate patients from the emergency department and wards as well as accepting referrals from GPs for assessment and had asked the matron to encourage ward managers to give more thought to patients that could use the unit for treatments on a day care basis rather than staying in hospital.

The FEAST team carried out two-hourly board rounds to ensure tests were completed and patients were discharged in a timely way, they also actively looked for and pulled patients waiting to be seen from the emergency department and CDU if they were suitable for their unit.

During the inspection the bed state was at 100% occupancy with medical outliers on two surgical wards and one orthopaedic ward. We were told that outliers were managed by using a ‘buddy system’ which ensured they were seen by a doctor every day and that tests were initiated and results were reviewed. This did mean that the doctor seeing the medical outliers was not necessarily part of the patient’s consultant’s team and patients sometimes were transferred to a different consultant when they moved wards.

We saw that all medical wards had a mix of patients which meant they were not always on the speciality ward relevant to their needs. We saw that this had been added to the risk register in September 2016 “Ensure that the designation of the speciality of some medical wards reflect the actual type of patients treated at Scunthorpe General Hospital and Diana, Princess of Wales Hospital and there were mitigations in place i.e. patient specific needs are currently identified by the acute medical team and transferred to the appropriate wards. This is facilitated by the bed management team and intra ward transfers are undertaken if patient specific needs changes.” Although this risk had been reviewed regularly since it had been placed on the register there were no new updates and when asked the senior management team acknowledged that they had not thoroughly explored or quantified this issue and there were no plans to take specific action regarding this as the problem was tied up in bigger capacity issues.

Although the hospital aimed to have golden discharges (before 12 noon) there were none of these recorded in the discharge lounge on the day of the inspection.

WebV highlighted length of stay using a traffic light system alerting managers/ matrons to ensure reviews had happened for long stay patients. Patients are highlighted as red when they have been in hospital for 10 days.

We reviewed two sets of long stay patient medical records on ward 24, one patient record had entries most days but the other had clear gaps over weekends and bank holidays. The notes
indicated there were delays in receiving and reviewing radiology investigation results and both patients had waited for five days from referral to review by the vascular surgical team.

Staff on PIU told us that they were not always able to see Gastroenterology patients who required monthly infusions in a timely manner.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From January 2017 to December 2017 the trusts performance has been stable but consistently worse than the England average.

In the most recent month, December 2017, the trust’s referral to treatment time (RTT) for admitted pathways for medicine showed 69% of this group of patients were treated within 18 weeks versus the England average of 89%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Two specialities were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>94.9%</td>
<td>93.2%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>62.5%</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

At our last inspection we found there were a high number of two-week and urgent breaches occurring in endoscopy over the previous year from April 2016 to November 2016 (387) and there were also 2,194 patients waiting for a follow-up appointment. At this inspection we found the endoscopy team had worked hard to reduce the number of breaches and this had now been resolved. At 13 June 2018 there were only two breaches of the two-week and urgent target and the current waiting list position for SGH at 4 June 2018 was 532 patients. The clinicians we spoke with were confident they could reduce the waiting list completely and be able to apply for re-accreditation in October 2018. A business case to further this recovery was developed in early June 2018.

**Patient moves per admission**

The trust provided data on patient moves per admission for non-clinical reasons for each hospital site. However, they did not supply a break down at individual ward level and as such it
should be noted that the figures below could include figures for both surgical and medical wards.

**Trust level:**

During 2017, 95% of patients at trust level did not move wards during their admission, with 4% moving once and the remaining 1% reported moving wards more than once.

**Scunthorpe General Hospital:**

During 2017, 97% of patients at Scunthorpe General Hospital did not move wards during their admission, with the remaining 3% of patients reported to have moved wards once or more. Although a small proportion of total patients, 21 patients were moved three times or more. The number of bed moves was better than the previous year. Trust data showed that from January 2017 to December 2017 there were 371 patients moved at night at SGH, usually ranging between 25 and 35 each month, with one peak of 51 patients moved at night during March 2017.

*(Source: Trust Routine Provider Information Request - P51 – Bed moves)*

Patient feedback was mixed regarding bed moves, patients on ward 17 told us there was little movement at night but medical outlier patients on ward 28 told us they had been moved several times late at night/ early hours of the morning. They told us there was too much movement and noise at night to be able to sleep.

Some staff told us it was difficult to get outlier patients reviewed by the correct medical team. Staff on the planned investigations unit told us that their bed spaces had been used at times for medical outlier patients at night and weekends when the unit was shut. Staff had been brought in from other areas to look after the patients when this happened, this would be one RN from a ward and one bank or agency nurse to look after up to six patients. Usually the unit was open from 8am to 8pm and if patients were not ready for discharge the patients were transferred to a ward for an overnight bed. The number of outliers during the day hadn’t prevented planned investigations going ahead but the unit staff took over inpatient care during the day and felt there was little understanding from other areas regarding the acuity or number (up to 30) of their usual patients, they did not generally get any more staff to care for the inpatients during the day. There were no inpatients on the unit at the time of our inspection. The unit was fully staffed and over established with HCAs. Two of the HCAs were going to do their nurse training in September (self-funded).

Staff in the Cath Lab told us that received one week’s notice for elective lists and where slots became available they could add in extra patients. Staff were concerned about capacity in this area and told us that if certain coronary interventions ran over their allotted time then some patients could be sent home without having had their procedure completed.

We visited ward 10 which was a 24-bed orthopaedic ward as there had been 13 medical outliers on that ward earlier in the day. The ward manager told us that there were now three medical consultants that visited the ward every day which was a big improvement. They felt that admissions were not always appropriate and that staff were not necessarily skilled to care for acutely ill medical patients. Senior staff were happy to challenge the site manager and negotiate for a lower acuity patient but when junior staff tried to do this they were overruled which left them feeling bullied and intimidated. They told us it was not unusual for staff to be found in tears because they have had to take patients they didn’t feel skilled enough to care for properly.

During the day, we were told that if staffing fell to two registered nurses if one needed to go to theatre it left staff vulnerable and in a potentially unsafe situation if any of the medical patients were to deteriorate. The ward manager felt this issue was raised with senior managers but wasn’t listened to or considered when moving patients. We were told that staff had left because of the way they had been treated or spoken to and there was a concern that other staff would leave.
Staff told us they had taken these issues to senior managers and the chief executive but were unaware what or if any action was being taken.

**Mixed Sex Accommodation Breaches**
We saw that the high observation bay on ward 22 was single sex on the day of our inspection, however we saw notices for patients to inform them that this could be a mixed gender area if both male and female patients needed NIV. Staff told us that they made an incident report every time a mixed sex breach occurred.

National guidance indicates that it is acceptable to have level two patients in mixed sex accommodation, however level one patients must not be mixed. There were 68 mixed sex accommodation breaches in the medical service at SGH from February 2017 to January 2018. All but five of these breaches were recorded as being on ward 22.

Staff in the Cath Lab told us they felt they had temporary mixed sex breaches in the recovery area as patients were only separated by curtains. These did not meet the criteria for external reporting but this was an area of concern for staff.

**Delayed Discharges**
We looked at the trusts delayed discharge figures from February 2017 to January 2018. There were 586 reported delays for SGH. However, we saw a decline (improvement) in delays from February 2017 to January 2018 with the numbers falling from 84 in month 1 to around 40 in month 12.

SGH had a discharge lounge which was open from 9am until 7pm Monday to Friday and 9am to 5pm weekends.

The trust employed patient flow or discharge coordinators. We spoke with a member of staff from the team who explained that part of their role was to assist in arranging the transfer of patients from the medical assessment unit to other wards and to facilitate discharge for medically fit patients. We were told that timely and safe discharges were a priority. To achieve this discharge coordinators liaised with patients’ families, social care teams, community nursing teams and care homes. If necessary, they were able to arrange home support and arrange equipment.

We attended a trust operational management meeting. These took place four times each day, these meeting were used to establish patient flow issues, staffing issues and the capacity and demand on each hospital site.

Staff at the trust told us that reasons for delayed discharges included funding issues for some patients out of area and sometimes nursing or care homes refused to take patients back when they felt they couldn’t meet a patient’s increased care needs. Transport could also be an issue, however there was also evidence of patients who were fast-tracked to ensure they were able to be at home if they were in the last days of life.

**Learning from complaints and concerns**
From February 2017 to February 2018, there were 115 complaints about medical care. The trust took an average of 52 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 30-45 working days, or 60 days for complex complaints. There were 49 complaints about medical services at SGH.

A breakdown of the main subject of complaints in medical services is shown below:

<table>
<thead>
<tr>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
</tr>
<tr>
<td>63</td>
</tr>
</tbody>
</table>
Admissions and discharges (excluding delayed discharge due to absence of care package) 13
Communications 12
Values & behaviours (staff) 7
Access to treatment or drugs 6
Privacy, dignity & well being 3
Appointments 3
(blank) 2
End of life care 2
Other (specify in comments) 1
Waiting times 1
Consent 1
Facilities 1

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We saw posters displayed in most ward areas about how to raise a concern. We did not see information regarding how to make a complaint or raise a concern on ward 17 or CCU but patients told us they knew about PALS and how to make a complaint and one said they had seen the information previously. The board on ward 17 had recently been tidied and it was thought the information had been misplaced. On CDU we saw forms for patients and visitors ‘this is my complaint’ and ‘what will make things better?’, we also saw that there was information covering most frequently asked questions. Cath lab had complaints and duty of candour information on display. Staff we spoke with displayed a good understanding of duty of candour.

We saw information from a complaint displayed in the staff room and staff told us this was a good thing as it reminded them to think how relatives may see things.

Compliments
From February 2017 to January 2018, the trust reported 30 compliments for medical care being logged by a central team on the DATIX system. 15 of these were for Diana Princess of Wales Hospital, 13 were for Scunthorpe General Hospital and the final two were for Goole and District Hospital. Please note however, that any compliments sent directly to staff members are not logged using this system, therefore we are unable to know the exact number received by the trust. The trust did not provide any additional information about these compliments; therefore, we are unable to comment on themes.

(Source: Routine Provider Information Request (RPIR) Compliments)

Positive patient feedback was displayed in some of the areas we visited.

Is the service well-led?

Leadership
The medical service was led by a triumvirate of an associate divisional clinical director (DCD), associate chief operating officer and an associate chief nurse (ACH). The DCD and the ACN were both recently appointed to their roles. Staff spoke highly of the ACN, staff said they were accessible, approachable and listened to them.
The senior leaders were working to improve team working and share good practice / more effective ways of working across the hospital sites. They recognised that there were different ways of working at SGH and DPoW and each hospital had its strengths and weaknesses. They were aware of the difficulties they faced to encourage changes in practice to make services more streamlined and equitable in terms of quality and effectiveness.

The team told us they were aware the trust board had not always been fully supportive of implementation of difficult (agreed) change and told us they had been clear with the board that they needed their full support and backing when difficult choices / changes were made. The senior leaders felt that changes to the board of directors had been positive and that they had the board’s support.

We found that there was a clear leadership structure at clinical level. All wards had a ward manager who were supported by operational and quality matrons and the ACN. Ward managers we spoke with also told us matrons and ACN were approachable and visible on the wards.

Ward managers had limited time to carry out their management duties as they were counted in the nursing numbers four days out of five. Feedback from staff regarding the leadership on all medical wards was positive and staff told us they were well supported. A healthcare assistant said that the local leadership was brilliant.

We found that Cath Lab staff were a positive, forward thinking team who were complementary about their leadership. Ward managers told us that matrons were supportive, approachable and accessible.

CCU and ward 16 staff told us they did not have staff meetings but used a communication book and used a staff only Facebook page. Ward 24 had a new ward manager and a new deputy, there had not been any staff meetings for some time but the new manager was planning on reinstating these. We saw minutes from the April 2018 staff meeting on ward 22.

Staff were very complimentary about their immediate line mangers / ward mangers and stated that they were very supportive and they could raise concerns which would be dealt with.

Staff on the stroke unit told us they had regular staff meetings and that they had a communications book to share important information from incidents and complaints. The PIU manager also held meetings for their staff every 2-3 months and notes from the meetings were shared with staff not present.

CDU staff told us it was difficult to have meetings often but they did have ‘catch ups’ as part of handovers. We also saw notes of the April 2018 meeting displayed on the staff notice board which included the outcome of an incident investigation which was for additional training to be provided regarding insulin prescribing and administration including fixed and variable rates.

Staff in most areas told us they were well-supported. Support staff on the stroke unit told us they felt valued and part of the team, they felt the multidisciplinary team worked well together and everyone valued each other’s roles and contributions. They felt managers were supportive and told us they would not have any problems raising concerns.

The discharge lounge appeared to lack senior leadership however staff thought this was an important area as it was the patient’s last experience of their hospital stay and this should be a good experience. The lounge was managed on a day to basis by a band 5 staff nurse with support from HCAs. The matron visited this area but staff said they did not see anyone more senior. The band 5 nurse was due to retire soon but was unaware if any recruitment had started to replace them.
Staff on the discharge lounge felt it was under used and had spoken to the matron about this to encourage increased use. The matron had emailed other matrons to cascade to ward managers, clear statements about what the discharge lounge staff could offer and which patients were inappropriate for the area. It was hoped that this initiative would encourage an increase in uptake of the service.

There were a small number of negative comments regarding senior management / leadership. Some ward managers felt that they weren’t always listened to regarding patient flow and accepting patients onto wards that were already under pressure, they told us they had taken these issues to senior managers and the chief executive but were unaware what or if any action was being taken.

**Vision and strategy**

The trust was in the middle of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the medical service for 2018/2019 but we saw for 2017/2018 there was a business plan that covered SGH, DPoW and GDH. This took into consideration commissioning intentions and the strategic transformation plan objectives. There was an analysis of the strengths, weaknesses, opportunities and threats to the service and several priorities for improvements and developments were tabled. We found that a number of the developments had taken place as planned such as; ‘SAFER red2green days’ process had been introduced at SGH and DPoW to highlight long stay patients with the aim of reducing unnecessarily long admissions.

For 2018/2019 the service had project plans and work was ongoing to embed or further develop across the trust; the medical model, the frailty service/ pathway, ambulatory care and ‘SAFER red2green’. There was a draft strategy developed for the haematology service who were working in partnership with Hull and East Yorkshire Foundation Trust and the Queen’s centre to ensure sustainable service. The business and project plans did not cover all the specialities including cardiology which had been identified by the trust, during our interview with the triumvirate as a fragile service. However, a ‘Listening into Action’ event was planned for cardiology staff to look at how the service was to be taken forward and to develop a vision and strategy.

There was a trust wide staff retention strategy which focussed on delivering; culture transformation, instilling pride and belonging within the workforce, a review of reward and recognition incentives, staff wellbeing initiatives, staff engagement regarding quality improvement, career investment and looking at improving the work/life balance of all staff. We found evidence that the triumvirate were aware of this strategy and were working towards delivering the outcomes. We saw evidence that the DCD and ACN were working with staff to improve engagement and improve services. The ACN was a good role model regarding caring for staff and thereby improving care for patients.

The dementia lead told us there was a dementia strategy and plan and the trust had recently introduced a delirium policy and care plan as part of this. A local dementia steering group had been formed and was co-chaired with a member of the commissioning group. The trust was also working with the Humber Coast and Vale sustainability and transformation (STP) steering group. The dementia lead had a clear vision and focus for the next 12 months and understood the challenges to delivery.

**Culture**

During our inspection, we found staff were open and honest. They told us the culture on the wards was positive and they spoke about good team working.

All staff we spoke with told us they felt confident to approach their line managers if they were unhappy about something.
We spoke with the leadership team who told us they were aware that there was a feeling among some staff that there was still a legacy of bullying and intimidation in some areas of the trust and that they were actively trying to identify specific areas of concern and take action to improve this. There were some workshops planned for staff to take part in improving the culture of the trust.

Staff we spoke with told us they were proud of their unit or service and their team members.

Some staff felt that nurses hadn’t had a loud enough voice at the trust but that this was improving and they weren’t afraid to speak out.

There were a small number of staff who had concerns regarding bullying and one did not know about the whistle-blowing policy. Some staff were unsure who to report concerns to due to changes at matron level and felt unsupported/listened to.

Junior doctors reported poor communication with consultants regarding the management of medical outliers.

Two patients (medical outliers) commented that they felt the communication between the doctors was poor as they gave different information. One patient told us they had been under the care of three consultants since admission.

**Governance**

The medicine group had a clear governance structure for acute and planned care. Governance structures were in place that provided assurance of oversight and performance against safety measures. We reviewed the quality and safety committee minutes and found discussion around current risks and performance. Information was discussed at these meetings from the different speciality groups.

The quality matrons completed observational audits to provide assurance that the appropriate care was being given to patients. These included; reviewing care records of the most vulnerable and the sickest patient on the ward, observing if patients looked cared for, how the ward felt, and patient/relative feedback.

A ward assurance tool the ‘Adult Nursing Audit Dashboard’ was in place that collated information from monthly audits. This looked at physiological observations, completion of risk assessments and other patient safety indicators. Results were reported as part of the nursing audit dashboard and identified areas for improvement or where support was needed.

Managers told us that the ward assurance tool process was being redeveloped as part of the Trust’s Improving Together and has now been approved by the Trust’s senior nursing team, the implementation roll out plan is currently being developed.

**Management of risk, issues and performance**

We reviewed the medicine risk register, which contained 61 risks. All risks had been reviewed several times throughout 2017 however many risks had little information in the way of updates and simply stated ‘risk reviewed, to remain on register’. For example, there was no comment or progress recorded for an action initiated in 2016 to review the clinical pathways for PIU. This did not assure us that actions regarding risks were effectively overseen or communicated to the reviewer.
The trust had a business continuity and strategy policy. This document contained details about how the trust would respond to an incident or event, which could disrupt services and contained details of the key individuals to support staff.

In addition, there was also a trust major incident plan. This was in date and contained appropriate guidance, contacts and level of escalation based on risk.

We spoke with the senior managers for the medical service who told us about their main concerns / risks, these included medical and nurse staffing and staff engagement / changing culture, compliance with training and remodelling of services/ pathways. Mitigating actions were explained, for example for staffing this included recruitment and retention plans / strategies, alternative staffing models and escalation plans.

**Information management**

Information provided by the trust, showed that 66% of trust medical staff and 44% of medical staff at SGH had completed information governance training. Nursing staff compliance was better at 83% trust wide and 80% at SGH. The trust target was 85% of all staff to have completed this training. We did not have any concerns about the security of patients’ records at this inspection.

Computers were available on medical wards; staff could access policies and clinical guidelines via the trusts intranet.

The trust had electronic systems in place for staff to request clinical tests for patients and view reports and x-rays.

Data provided by the trust, showed that 80% of nursing staff at SGH had completed information governance training. This was slightly below the trust target of 85%. However, medical staff were well below the trust target with 44% compliance.

Staff told us that sometimes there was a delay between staff undertaking training and information being entered or pulling through on the Electronic Staff Record System (ESR).

**Engagement**

The trust provided details of senior management ward walkabouts and visits. Some, but not all, staff told us that they saw the executive team.

We saw that the ACN had held engagement events for ward managers to develop objectives for nursing and for matrons to discuss their current role and vision for the future. Following the ward manager event, it had been agreed to hold a series of events over a year for staff nurses and HCA’s to look at their working day, the stressors, the celebrations and how they are feeling and how they can be engaged to enjoy their work.

Matrons and ward managers agreed a focus on three key areas; having a reputation within the group for being really good at fundamental nursing care, with a focus on NEWS / Care rounds / Sepsis; improving staff health and wellbeing and making education and training meaningful and up to date within clinical areas. Information was submitted to the wards to understand what these three areas meant to the ward staff, what would they want to see, how would they want to be involved?

The engagement activities demonstrated that the ACN was working to instil her view that ‘Caring for our patients is dependent on caring for our staff’.
Staff told us they felt more needed to be done to retain staff and that more could be done to recognise excellence and innovation to improve services. Some managers felt that the trust needed to make working more flexible for nursing staff as they had seen large numbers of staff leave or go to work in more family friendly areas when shift patterns had changed. We spoke to one agency nurse who told us they had left their substantive job at the hospital and joined the agency because they had childcare issues.

The service participated in the friends and family test and CQC Inpatient survey.

The trust participated in ‘Way Forward’ public engagement events in partnership with North East Lincolnshire Clinical Commissioning Group (CCG) and other health and social care providers, to share their ideas about services for the years ahead. These events had been held at each of the three hospitals over the last 18 months and provided information about national, regional and local developments in health and care and the CCG’s commissioning intentions for 2018. The Trust gave information about the progress that had been made around improving quality, performance, finance and emergency care at Grimsby and Scunthorpe Hospitals. There was a choice of discussion groups for patients / the public to attend to look in more detail at specific health and social topics and have your say. A consultant from the haematology service facilitated one of the groups in March 2018. The CCG and Trust Patient Advice and Liaison teams were also at these events to listen to any complaints, compliments or any enquires about health and care services. Feedback from the events was mixed with attendees finding the sessions informative but not enough time to give opinions and suggestions, a feeling that service developments had already been decided and future sessions needed to be clearer about what the public could contribute. Members of the medical management team also attended the local health scrutiny meetings.

**Learning, continuous improvement and innovation**

We saw examples of innovation to improve services such as; clinical nurse specialists providing a Respiratory In-Reach service at SGH and initiating a follow-up clinic on a Saturday for Chronic Obstructive Pulmonary Disease (COPD) which has enabled the service to meet the standard for these patients to be reviewed within 48 hours. Clinicians felt that these initiatives had helped improve patient outcomes.

The respiratory / COPD MDT was held weekly to discuss all COPD patients in hospital. Asthma cases were also discussed at this meeting. Reports from this meeting are available for GPs to directly access. The service received a Royal College thank you for this and for performing spirometry whilst patients are inpatients. The Royal College of Physicians would like the trust to share this best practice with them.

The Immunology service had worked with Lloyds Pharmacy to enable injections for a medicine to treat asthma to be given in a community clinic rather than patients having to attend the PIU at SGH.

The endoscopy unit was carrying out extra sessions over seven days a week to clear the waiting list to enable them to re-apply for JAG (Joint Advisory Group on Gastrointestinal endoscopy) accreditation in October 2018. There was a good system in place to ensure 2-week wait targets were met and urgent patients were seen quickly. Less urgent patients were pre-assessed at Scunthorpe hospital but could choose to have their endoscopy at SGH or at DPoW.

The endoscopy service had one trained nurse endoscopist but was hoping to develop another member of staff to provide cover and make the service more sustainable, currently with only one nurse endoscopist, the service did not meet Inflammatory Bowel Disease (IBD) standards.

The staff in the PIU were planning on developing a weekly drop in service for patients with inflammatory Bowel Disease (IBD). Staff felt the management team had improved over the last year and the assistant associate chief nurse was supportive of new ideas to improve services. The
PIU was developing a portfolio of criteria for the different investigations they carried out and staff were working with staff in at a similar unit at DPoW through video meetings.

There was a 24-hour GI bleed rota in place across the two hospital sites and anaesthetic support was obtained from the general anaesthetist on-call rota.

We saw evidence of the effectiveness of the FEAST team, working both in the hospital and with community-based partner services and organisations, to provide the most appropriate care for frail elderly patients. This service was demonstrating positive outcomes and had been shown to be reducing avoidable hospital admissions. Due to its success this model was to be developed out at DPoW hospital.

Staff on the ambulatory care unit had initiated an outreach service for treatments which could be given at home such as intravenous antibiotics and certain nebulised medicines, they were working to improve awareness of this service and ambulatory care to increase use of the services and contribute to reducing pressure on other areas of the hospital in relation to capacity and patient flow.

Surgery

Facts and data about this service

Surgical services are provided at all three hospital sites, providing 228 beds and 10 high observation beds (HOBs) over 14 wards:

Scunthorpe General Hospital has five surgical wards. The surgery directorate provides acute, elective and day case surgery covering 10 surgical specialities. There are eight theatres, providing surgery in general surgery, breast, colorectal, upper gastro-intestinal, trauma and orthopaedics, ophthalmology, ENT, orthodontics, maxillofacial and urology specialties. There is one theatre dedicated to emergency surgery at all times.

(Source: Acute Routine Provider Information Request (RPIR) – AC1 Context)

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

- Ward 10 – 16 beds
- Ward 11 – 15 beds
- Ward 25 – 24 beds plus four HOBs
- Ward 28 – 28 beds
- Ward 27 – day surgery

(Source: Routine Provider Information Request (RPIR) – P2 Sites)

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

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
At the 2016 inspection, the trust target for mandatory training compliance was 95%; since the inspection the trust had lowered the compliance level to 85%. Current compliance rates for medical and dental staff was 57.6% and 77.5% for nursing staff, both rates were below the trust target of 85% and both rates had decreased from 2016 inspection compliance rate of 82%.

A breakdown of compliance for mandatory courses February 2017 to January 2018 for medical and dental staff by site is shown below:

**Trust level**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>146</td>
<td>181</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>134</td>
<td>181</td>
<td>74%</td>
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<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>128</td>
<td>181</td>
<td>71%</td>
<td>85%</td>
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</tr>
<tr>
<td>Resuscitation</td>
<td>113</td>
<td>169</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
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<td>181</td>
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</tr>
<tr>
<td>Manual Handling - People</td>
<td>87</td>
<td>161</td>
<td>54%</td>
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</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>89</td>
<td>181</td>
<td>49%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>88</td>
<td>179</td>
<td>49%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>81</td>
<td>181</td>
<td>45%</td>
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</tr>
<tr>
<td>PREVENT Level 1</td>
<td>71</td>
<td>181</td>
<td>39%</td>
<td>85%</td>
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Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>71</td>
<td>88</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
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</tr>
<tr>
<td>Equality and Diversity</td>
<td>65</td>
<td>88</td>
<td>74%</td>
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</tr>
<tr>
<td>Resuscitation</td>
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<td>87</td>
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</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
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<tr>
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<tr>
<td>Fire Safety 2 years</td>
<td>42</td>
<td>88</td>
<td>48%</td>
<td>85%</td>
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</tr>
<tr>
<td>Conflict Resolution</td>
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<td>48%</td>
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<tr>
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<tr>
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<td>37</td>
<td>88</td>
<td>42%</td>
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</table>

The overall mandatory training completion rate for medical and dental staff in surgery was 58.7% at trust level, 57.6% at Scunthorpe General Hospital. This was below the trust target of 85%.

At site level, the trust target was not met in any mandatory training module at Scunthorpe General Hospital.

A breakdown of compliance for mandatory courses February 2017 to January 2018 for qualified nursing and midwifery staff by site is shown below:

**Trust level**

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<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
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</thead>
<tbody>
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<td>Conflict Resolution</td>
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<td>Infection Control - 1 Year</td>
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</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
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</tr>
<tr>
<td>Resuscitation</td>
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<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
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</tr>
<tr>
<td>Manual Handling - People</td>
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<tr>
<td>PREVENT Level 1</td>
<td>214</td>
<td>306</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
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</table>

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>96</td>
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<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
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</tr>
<tr>
<td>Information Governance</td>
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<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
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<td>85%</td>
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<td>Slips, Trips &amp; Falls</td>
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<tr>
<td>Infection Control - 1 Year</td>
<td>76</td>
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<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>74</td>
<td>103</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>74</td>
<td>104</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>70</td>
<td>103</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
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</tbody>
</table>

The overall mandatory training completion rate for nursing and midwifery staff in surgery was 78.1% at trust level, 77.5% at Scunthorpe General Hospital. This was below the trust target of 85%.

At site level, the trust target was met in two out of ten modules at Scunthorpe General Hospital. (Source: Routine Provider Information Request (RPIR) – P40 – Statutory and Mandatory Training)

Mandatory training was completed either online or through classroom based training.

The majority of staff that we spoke to had completed their mandatory training or were booked onto outstanding courses.

The trust had a monitoring system in place on the intranet which operated a traffic light system and sent staff and managers reminder emails when mandatory courses were due for renewal.

**Safeguarding**

At the 2016 inspection, the target level for safeguarding training was 95%. The training compliance level was 83% level one, 82% level two and 50% level three.
At this inspection, the target level for training had decreased to 85%.

A breakdown of compliance for safeguarding courses February 2017 to January 2018 for medical and dental staff by site is shown below:

Trust level

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
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<tr>
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<td>71%</td>
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</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>127</td>
<td>181</td>
<td>70%</td>
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</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>120</td>
<td>181</td>
<td>66%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>65</td>
<td>88</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>64</td>
<td>88</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>60</td>
<td>88</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for medical and dental staff in surgery was 69.1% at trust level, 71.6% at Scunthorpe General Hospital. This was below the trust target of 85%.

A breakdown of compliance for safeguarding courses February 2017 to January 2018 for nursing and midwifery staff by site is shown below:

Trust level

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>258</td>
<td>306</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>252</td>
<td>306</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>251</td>
<td>321</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>88</td>
<td>103</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>85</td>
<td>103</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>93</td>
<td>118</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The overall safeguarding training completion rate for nursing and midwifery staff in surgery was 81.6% at trust level, 82.1% at Scunthorpe General Hospital. This was below the trust target of 85%.

The service had systems in place for the identification and management of adults and children at risk of abuse.

At this inspection, staff we spoke with said that they had completed adult and children’s safeguarding as part of their mandatory training. They also said that the trust safeguarding team was accessible and supportive when staff needed advice about safeguarding concerns.

The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse, and issues which staff should report. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern and knew how to raise them.

Staff we spoke with could provide examples of safeguarding such as pressure damage acquired in hospital.

Cleanliness, infection control and hygiene

At this inspection, we found the wards and departments we visited visibly clean and tidy. We reviewed patient led assessments of the care environment (PLACE) reports for 2017 and noted 99% compliance for cleanliness better than the 98% England average.

The trust had an infection, prevention and control policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination and personal protective clothing.

Records we reviewed showed that that not all staff had completed infection prevention and control training 42% of medical and dental staff and 75% nursing staff had completed training. This was below the trust trusts compliance target of 85%.

We saw information displayed on the wards and departments we visited celebrating the number of days since the last hospital acquired clostridium difficile (C. diff) and Methicillin-resistant staphylococcus aureus (MRSA) isolate.

The directorate reported no cases of hospital acquired MRSA from April 2017 to March 2018. The trust reported no cases of C. diff in the same reporting period. This was lower than the trajectory of 21 cases, the agreed threshold for 2017/2018.

The trust had a policy to screen surgical patients for MRSA and some patients for methicillin-sensitive staphylococcus aureus as per best practice guidance.

The infection prevention and control team carried out surgical site infection surveillance data we reviewed showed six patients had reported an infection following primary hip replacement surgery, out of 703 operations performed, this equates to a rate of 0.9% which was worse than the national rate of 0.6%. Primary knee replacement surgery showed four patients had reported an infection following surgery, out of 784 operations performed, this equates to a rate of 0.5% the same as the national rate.

Quality matrons conducted monthly audits including the patient environment and infection, prevention and control. We saw how the data was used to populate a ward dashboard. Data we reviewed showed that the Infection, prevention and control team validated this data on a monthly basis.

During the inspection, we observed that staff were compliant with hand hygiene policies, including ‘bare below the elbows’ and personal protective clothing policies.
Handwashing advice was clearly displayed and facilities for hand hygiene were available. Hand hygiene compliance data was displayed on wards we visited. We observed staff decontaminating their hands appropriately. Staff had access to at the point of use alcohol gel.

We inspected reusable equipment stored on the ward, and all items appeared to be visibly clean and ready for use. We observed staff cleaning and disinfecting equipment between patients, which followed the trust policy. We did not see that staff used a specific label to identify the equipment was clean and ready for use. We reviewed five pieces of reusable clinical equipment and found these to be clean but not labelled.

Staff we spoke with said that they had access to appropriate personal protective clothing (PPE). We observed staff using gloves and aprons appropriately.

We saw processes for segregation of waste including clinical waste. Staff were able to segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment. Sharps bins in the areas visited were secure, dated signed and stored of the floor. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.

Rooms were available for patients requiring isolation, and during the inspection, patients requiring isolation were isolated appropriately.

**Environment and equipment**

At the 2016 inspection, we said the trust they should ensure that resuscitation equipment was regularly checked and tested consistently and in line with trust policy. At this inspection, we saw improved processes, all equipment we reviewed was clean, tidy, ready for use and staff had checked the equipment as per trust policy. Trolleys we inspected were locked, appropriately stocked and equipment was in date.

The theatre department had a numbers of areas which required refurbishment, we saw damaged doors showing bare wood and chipped, cracked plasterwork, we also saw an area used for theatre storage had evidence of water damage, poor maintenance and windows which did not prevent access of insects or rain. This did not show compliance with infection, prevention and control precautions including cleaning or provide assurance of compliance with health building note HBN 26 Facilities for surgical procedures or HBN 00-09 Infection control in the built environment.

Theatre staff had developed a procedure to store sterile theatre trays in plastic bags in this area to prevent contamination and damage. We reported this at the time of the inspection, and the senior management team visited the area with executives and arranged for remedial action to be carried out. Following the inspection, the senior management team confirmed that remedial work had been completed and they had received approval for roof refurbishment.

Store rooms for theatres were cramped and equipment was stored on corridors, we witnessed three pieces of equipment and a number of theatre trolleys stored on public corridors outside of theatres. Storing the equipment on here could lead to damage. Patients accessing theatres had to go past external waste receptacles stored on the main corridor, waste in these bins was from maternity and staff we spoke with said that this led to odours on the corridors. The theatre department used lasers, during procedures warning hazard signs were illuminated both internally and externally to show treatment was underway. During the inspection, we did identify that on one occasions, one member of staff did not follow laser guidance and take appropriate precautions to protect themselves. Staff reported this as an incident at the time of the inspection.
The trust employed a Laser Protection Advisor (LPA) who was responsible for undertaking risk assessments, providing advice and training on laser safety. They also drafted local rules and investigated laser incidents. Records we reviewed, showed that local rules, training, staff competence, certification and checks had been recorded as per best practice guidance.

Staff we spoke with said that they had adequate stocks of equipment and we saw evidence of stock rotation.

We looked at seven pieces of equipment and found the majority to have been safety tested within the review date.

The corridor opposite the nurse’s station on ward 28 was cluttered with equipment. This made it difficult to manoeuvre patients on beds through the ward.

We reviewed patient led assessments of the care environment (PLACE) reports for 2017 and noted 94% compliance for condition, appearance and maintenance the same as the 94% England average.

**Assessing and responding to patient risk**

At the 2016 inspection, we said that the trust must ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist was implemented consistently within surgical services. During this inspection we saw improvements and it was clear that this had become embedded as a routine part of the surgical pathway.

We observed 15 occasions when the surgical checklist was in use, on all the occasions this was effective. We reviewed five sets of completed checklists in patient records and saw that these were completed appropriately at the time of the operation. We asked to review internal compliance data of the checks by the trust, this showed that the directorate scored 99.3%, 99.2% and 99.8% January to March 2018, slightly below the 100% compliance score.

Patient safety briefings were carried out pre-operatively; these included introductions from the clinical team, the order of the list, additional equipment anticipated and the addition of emergency patients.

During this inspection, the trust used the national early warning score (NEWS) tool; the trust had been an early adopter of the NEWS two pathway to improve safety and clinical outcomes. Surgical areas recorded electronically the patients early warning score using handheld or static computers. Nursing staff escalated any patient of concern to medical staff. Nursing staff we spoke with could articulate the deteriorating patient and were able to describe when they would escalate to medical staff.

We reviewed five sets of medical records and we saw appropriate evidence of escalation. We asked to review internal compliance data of the checks by the trust, this showed that the directorate achieved 100% compliance in the audits September to November 2017.

At the 2016 inspection, we did not see that patients were assessed for surgery in accordance with effective pre-assessment pathways. At this inspection, we saw some improvements in surgical pathways, however, we were still aware that not all patients requiring pre-assessment would be booked appropriately. Staff working within the directorate were aware of patients that had been listed for surgery without seeing them, this had led to cancellations of their planned surgery on the day of admission. The changes needed more pace and a further period of embedding to provide assurance that the service was effective and responsive to clinical needs.
Staff we spoke with said that they had received sepsis training and staff we spoke with could articulate the signs of sepsis and were aware of actions required for escalation and treatment. We reviewed two sets of records and saw appropriate documentation and escalation.

At the 2016 inspection, we said that the trust should ensure that patients are assessed for delirium in line with national guidance. At this inspection we saw 80% compliance (March 2018) with dementia assessments.

We reviewed risk assessments including pressure damage acquisition, malnutrition, falls, bed rails, moving and handling we found that on the majority of occasions these were completed. Where necessary staff had identified patients of high-risk and referred these patients to further services such as tissue viability teams or dietitians to provide additional support, equipment or assistance.

Venous thromboembolism VTE assessments we reviewed showed good levels of completion.

**Nurse staffing**

At the 2016 inspection, we said that the trust must ensure that there were at all times sufficient number (including junior doctors) of suitably skilled, qualified and experience staff in line with best practice and national guidance taking into account patients’ dependency levels.

At this inspection, we reviewed staffing fill rates for February 2018 and saw that the majority of shifts were scored above 85% for registered nurse shifts for both days and nights, only one area, ward 25 scored below 85%. The registered nursing fill rates for the areas were;

- Ward 25: 77% RN shifts days and 84% HCA shifts. Night shifts showed 100% RN shifts and 95% HCA shifts.
- Ward 28: 90% RN shifts days and 88% HCA shifts. Night shifts showed 99% RN shifts and 95% HCA shifts.
- Wards 10 and 11: 115% RN shifts days and 110% HCA shifts. Night shifts showed 97% RN shifts and 207% HCA shifts. The increase in rates in this area was due to an additional eight escalation beds being open during this time. Staff we spoke with confirmed that on the majority of occasions when escalation beds were open they had additional staff identified.

The trust reported their registered nursing and midwifery staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>82.98</td>
<td>76.98</td>
<td>85.84</td>
<td>79.44</td>
</tr>
<tr>
<td>Trust wide</td>
<td>7.52</td>
<td>8.52</td>
<td>7.52</td>
<td>8.72</td>
</tr>
</tbody>
</table>

The trust had a fill rate of 96.1% for nursing and midwifery staff in surgery in January 2018. For the previous year (January 2017) the trust had a nursing and midwifery staff fill rate of 93.3%.

We reviewed duty rotas over the last three months and examined 189 shifts. Data showed that all areas were staffed below established levels on a small number of occasions, however the number of agency and bank staff used to achieve the planned staffing levels was high. For example,

- We reviewed 63 shifts on ward 25, seven shifts were below established levels, and we saw 49 shifts had agency / bank staff in place.
- We reviewed 63 shifts on ward 28, five shifts were below established levels, and we saw...
61 shifts had agency / bank staff in place.

- We reviewed 63 shifts on wards 10 and 11, 28 shifts were staffed below established levels; and 78 banks and agency staff shifts used over this same period, this meant that on occasions more than two bank or agency staff were on duty per shift.

Although there were nursing staff shortages recognised by the senior management team on orthopaedics and trauma (wards 10 and 11), the transformation plan for this area included training staff to mobilise orthopaedic patients at weekends, however, it did not consider the low numbers of substantive orthopaedic staff or the high number of agency staff in use. Staff we spoke with, were complimentary about the agency staff that worked on the ward but did also say that the knowledge and skills of orthopaedic nursing were sometimes lower than substantive staff and continuity of patient care was problematic. To mitigate this, managers did try to block book agency staff but this didn’t always improve the situation. Over a four-week period we saw 62 different bank and agency staff booked.

The trust used the safer nursing care tool to monitor patients’ acuity and plan staffing levels, establishment reviews had recently been carried out and were awaiting approval at the trust management board. Staff escalated staffing issues through the site management meetings twice a day, these meetings were used to review activity, manage staffing issues and monitor capacity and demand on each site. The directorate used the SAFER (Senior review, all patients, Flow, Early discharge and Review) patient flow bundle, red2green initiatives and board rounds to improve safety and flow. The SAFER initiative involves five best practice safety elements to improve flow and discharge. The red2green campaign is a visual system to assist in the identification of wasted time in a patient’s journey, this approach identifies times patients spend in hospital without the day contributing to the patient’s discharge. The trust had recently employed a care navigator role to improve the patients journey and prevent or remove blockages in the patients discharge path.

Senior staff we spoke to said that retention of staff remained difficult, overseas recruitment was still occurring. On one ward, ward 25 they currently had 9.2 WTE staff with a 61% vacancy rate, this situation was due to get worse, when two members of staff went on maternity leave and the vacancy rate was predicted to increase to 84% from August 2018.

On the majority of occasions staffing levels in theatres were in line with the national recommendations for safe peri-operative care (AfPP) 2016.

Annual vacancy rates for nursing and midwifery staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>225.7</td>
<td>994.6</td>
<td>22.7%</td>
</tr>
<tr>
<td>Trustwide</td>
<td>-3.1</td>
<td>68.2</td>
<td>-4.6%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 15.5% for nursing and midwifery staff in surgery, which was above the trust’s target vacancy rate of 6.3%. Two sites did not meet the trust’s target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Annual turnover rates for nursing and midwifery staff in surgery from February 2017 to January 2018 are shown below, by site.
<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>8.07</td>
<td>82.21</td>
<td>9.8%</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0.00</td>
<td>5.00</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 8.6% for nursing and midwifery staff in surgery, which was lower than the trust's target of 9.4%. Scunthorpe General Hospital did not meet the trust's target for turnover rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates for nursing and midwifery staff in surgery from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>1,156.3</td>
<td>30,048.5</td>
<td>3.9%</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0.0</td>
<td>1,779.0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 4.4% for nursing and midwifery staff in surgery, which was higher than the trust's target of 4.1%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The nursing bank and agency staff usage by site is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0 (0.0%)</td>
<td>3,938 (55.9%)</td>
<td>1,038 (14.7%)</td>
<td>7,042</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>2,405 (25.6%)</td>
<td>5,053 (53.8%)</td>
<td>836 (8.9%)</td>
<td>9,391</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0 (0.0%)</td>
<td>1,116 (35.8%)</td>
<td>501 (16.1%)</td>
<td>3,116.00</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>1,073 (28.1%)</td>
<td>1,399 (36.7%)</td>
<td>251 (6.6%)</td>
<td>3,812.00</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018 there was a total of 11,396 nursing shifts filled by bank or agency staff in surgery, which represented 69.3% of all available shifts, and 11.4% of all shifts remained unfilled.

At Scunthorpe General Hospital there was a total of 3,588 nursing shifts filled by bank or agency staff in surgery, which represented 51.8% of all available shifts, and 10.9% of all shifts remained unfilled.
Medical staffing

At the 2016 inspection, we said that the trust must ensure that there were at all times sufficient number (including Junior doctors) of suitably skilled, qualified and experience staff in line with best practice and national guidance taking into account patients’ dependency levels.

At this inspection, for all surgical specialities a consultant was present on site 8am till 5pm Monday to Friday.

On call cover was provided by junior doctors. Foundation level doctors were supported by middle grade doctors. Staff we spoke with said that there were gaps in the medical rota; this was highlighted on the directorates health group risk register. The directorate had recognised that the failure to recruit substantive doctors had the potential to increase clinical and financial risks. In mitigation they had commenced weekly meetings to review medical staffing, partnership working agreements and more targeted recruitment. They had also increased the use of agency and locum staff within the directorate, however some gaps still occurred. The directorate also recognised that they had some fragile services due to being unable to recruit medical staff especially within urology, ear, nose and throat and trauma and orthopaedics. Nursing staff we spoke with highlighted issues relating to gaps in rotas such as delays to treatment, reviews, documentation and medicines prescriptions. They said that they supported the medical staff as much as possible.

Junior medical staff we spoke with said that they felt supported working in the trust and felt able to raise concerns as required.

Formal medical handovers took place twice a day during shift changes, we observed one medical handover and found this to be well organised, well attended and relevant information was discussed.

The trust reported their medical and dental staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>80.23</td>
<td>81.41</td>
<td>83.02</td>
<td>77.45</td>
</tr>
</tbody>
</table>

The trust had a medical and dental staff over-establishment of 0.3% in surgery with two out of the three sites having more staff in post than planned. For the previous year (January 2017) the fill rate was 97.3%.

Annual vacancy rates for medical and dental staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>254.4</td>
<td>990.7</td>
<td>25.7%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 24.7% for medical and dental staff in surgery, which was above the trust’s target vacancy rate of 6.3%. All three sites did not meet the trust’s target for vacancy rate.
Annual turnover rates for medical and dental staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>3.80</td>
<td>51.11</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 9.0% for medical and dental staff in surgery, which was lower than the trust’s target of 9.4%.

Sickness rates for medical and dental staff in surgery from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>240.0</td>
<td>11,967.0</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 2.6% for medical and dental staff in surgery, which was lower than the trust’s target of 4.1%.

The bank and agency staff usage by site is shown below:

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>694</td>
<td>1,786</td>
<td>14</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>531</td>
<td>851</td>
<td>3</td>
</tr>
</tbody>
</table>

The trust did not provide the total medical and dental shifts available, therefore bank and locum usage cannot be calculated.

In surgery, from February 2017 to January 2018, a total of 694 medical and dental shifts were filled by bank staff and 1,786 shifts were filled by locum staff. There were 14 shifts that remained unfilled.

As of October 2017, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average.

A number of changes to consultant job plans had occurred in the past year with the aim of improved service delivery, decreased waiting times and to increase elective orthopaedic care at Goole and District Hospital.
Records

Paper records were available for each patient that attended the wards and departments; the trust used electronic patient management to record key information about the patient’s hospital stay.

Electronic whiteboards were used on all wards we visited and these recorded key information about patient risks and treatment including flags for living with dementia, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

We reviewed 16 sets of records during the inspection and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of review or administration of treatment. Patients records were all stored in areas that were secure, and in locked trolleys and we did not see any patients notes left unattended.

We saw that patient records held individualised plans of care; for example, sepsis, pressure area prevention and falls care plans.

Medicines

At the 2016 inspection, we said that the trust must ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medicines are checked on a daily basis in line with the trust’s policy. At this inspection, we saw that staff recorded medicine refrigerator temperatures daily. We also saw action recorded if the temperatures were not within expected ranges.

Pharmacy services were available seven days a week, with an on-call service available out of hours and on a Sunday.

We checked that medicines were stored securely including controlled drugs on wards we visited. We saw medicines including controlled drugs were stored correctly with access restricted to authorised staff, they were checked in line with the policy and there were no discrepancies in controlled drug registers. Controlled drugs were audited by the nurse in charge of the ward on a weekly basis and checked on a quarterly basis by the pharmacy team. Following the inspection, the trust said that controlled drugs were now checked on a daily basis.

We reviewed seven medicine administrations charts and noted most medicines were prescribed and administered within national guidance.

We saw that prescribed antibiotics were not prescribed appropriately on six out of seven occasions, prescriptions were incomplete with no start, stop or review date available.

Nursing staff dispensed over labelled packs of medicines on discharge of some patients, over labelled packs were used to improve discharge times. Staff we spoke with said that two registered nurses always check the medicine dispensed was correct. However, this was not audited by the pharmacy team.

Incidents

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

At the 2016 inspection, we said that the trust must ensure that, following serious incidents or never events, root cause and lessons learned are identified and shared with staff. At this inspection, we
saw that from March 2017 to February 2018, the trust reported one incident classified as a never event for surgery. This was on the Diana, Princess of Wales Hospital site in July 2015.

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with in theatres at this hospital, said that they were aware of the never event, staff said that the trust shared information on the never event by newsletters and internal communication.

Serious incidents (SI) are incidents that require further investigation and reporting. In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from March 2017 to February 2018. Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with seven (23.3% of all incidents)
- Pressure ulcer meeting SI criteria with five (16.7% of all incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with five (16.7% of all incidents)

Site specific information can be found below:

- Scunthorpe General Hospital: nine incidents

(Source: Strategic Executive Information System (STEIS))

Ward managers said that if a serious incident occurred they would be involved in the root cause analysis process. We reviewed three serious incident reports; we found these to include contributing factors, identification of lessons learned and recommendations to prevent reoccurrence of the incident.

The service had systems in place for reporting, monitoring and learning from incidents. The trust had an incidents policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents. The trust also had an electronic reporting system in place and staff we spoke with could describe how they would report incidents.
Staff we spoke with said that although there was a positive culture for reporting incidents they did not report all incidents. They said that they did not report all staffing shortfalls and pharmacy staff did not think all medicine incidents were reported. Staff said that they did not do this because of the increased time spent reporting and investigating these incidents. Some staff had reported incidents recently, whilst others had not faced incidents recently and thus not had the opportunity to report incidents.

We spoke with seven staff and they all consistently said the top two incidents for their areas were falls and pressure sores.

Staff we spoke with said that the trust shared learning from incidents by staff meetings, through a file held in the sister’s office and on some wards a closed Facebook group and the intranet were used.

Safety huddles were used on all wards we visited, the senior management team said that these had increased communication and given increased structure to the working day. The safety huddles had recently been implemented and were used once a day to discuss the last 24 hours, the coming 24 hours, staffing concerns and ward incidents in the last 24 hours.

Staff we spoke with said that changes in practice had been implemented as a result of incidents occurring, these included changes in medicines checking procedures and changes in patient pathways.

Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain examples of when they would use this. Duty of candour requirements were detailed in all the reports we reviewed.

Staff we spoke with were aware of the duty of candour regulations, they could provide us with examples of when they would use this.

In the February performance report, we saw 100% compliance with duty of candour requirements.

For the surgical directorate we saw that the summary hospital level mortality indicator (SHIMI) and the hospital standardised mortality ratio (HSMR) were worse than target rates SHIMI 109 February 2018 and 106 March 2018 (target 95) and HSMR 110 February, 112 March 2018 (target 95). It wasn’t clear from meeting minutes we reviewed where this mortality data was discussed and used within the directorate or used to improve performance.

At the 2016 inspection, the directorate did not hold specific surgical mortality and morbidity meetings. At this inspection, the senior management team said that the cases were reviewed, and within audit meeting minutes we saw that the process of review had changed. The new process involved peer reviewing all patient deaths, identifying lessons to be learnt / discussion points. These cases would be discussed at the audit / mortality meetings. Within minutes we reviewed we saw that different processes occurred in different surgical specialities for example; orthopaedic teams had agreed to discuss all deaths however, ophthalmology had discussed removing mortality discussions from their agenda. The senior management team discussed with us that the process of discussion and sharing of learning from the reviews needed to be improved and had commenced new processes to improve compliance and identification of lessons learned.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 62 new pressure ulcers, 16 falls with harm and 20 new urinary tract infections in patients with a catheter (CUTIs) from December 2016 to December 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Northern Lincolnshire and Goole NHS Foundation Trust

![Graph](image1)

Total Pressure ulcers (62)

![Graph](image2)

Total Falls (16)

![Graph](image3)

Total CUTIs (20)

Prevalence rates of pressure ulcers remained similar over time except in September when a higher proportion of patients were reported to have a new pressure ulcer. Although prevalence rates of falls with harm and CUTIs varied over time, the numbers of reported incidents were low so any differences over time may not reflect changes in patient care.

(Source: NHS Digital)

During the inspection, we saw safety boards displayed on the wards we visited, these showed the results from the safety thermometer audits. These dashboards showed the number of pressure ulcers, fall and patient misidentifications. These were updated monthly. The boards on wards 25 and 28 were not up to date; i.e. they didn’t display the figures for the month of April 2018.

The information on the dashboards was collected by sisters and other senior nursing staff. The data was discussed at team meetings but these weren’t held regularly.

Venous thrombolysis (blood clot) assessments were carried out in the trust and the trust data we reviewed showed the trust was currently not meeting the VTE assessment indicator with performance of 92%, this was lower than the trust agreed target of 95%.
Is the service effective?

**Evidence-based care and treatment**

At the 2016 inspection, we said that the trust must ensure that policies and guidelines in use within clinical areas were compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies. At this inspection we saw that 88% of policies February 2018 were compliant with NICE.

During this inspection, we reviewed some of the trust clinical protocols and patient pathways used for patients on surgical wards; these included hip fracture pathways. The clinical director discussed with us some pathways that had been changed and others that still required changing to improve patient experiences for example; changes to ear, nose and throat pathways, urology services and services now being delivered from a single site.

We saw that patients’ treatment was not always based on national guidance, such as NICE or the Royal College of Anaesthetists and the Royal College of Surgeons, for example we saw that staff did not follow agreed protocols, pathways and best practice guidance especially in relation to access to theatres for patients with fractured neck of femur.

Policies were stored on the intranet and staff we spoke with could access them.

Wards and departments, we visited participated in local audit programmes called front line ownership audits. These audits had been developed to improve the patient experience and 10 criteria were reviewed on a monthly basis. These audits were also validated by the matron and infection, prevention and control team. Directorate data we reviewed for the month of April showed that three criteria scored red (less than 85%), four scored amber (between 85% and 95%) and 23 scored 95% or above.

The directorate held audit meetings where local surgical audit plans, were discussed. We reviewed seven sets of clinical audit meeting minutes and saw attendance from medical and audit staff and reviewing of the audit results.

**Nutrition and hydration**

We reviewed patient led assessments of the care environment (PLACE) reports for 2017 and noted 76% compliance for food and hydration which was worse than the 90% England average.

At this inspection, we saw that food and fluid charts were not always completed accurately. Staff did not total the daily intake and output on all fluid balance charts we reviewed.

Staff, by using the malnutrition universal screening tool (MUST) documentation, identified patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes. Patient records we reviewed showed good levels of completion. Staff also re-assessed patient’s nutritional status during the admission at regular intervals.

Pre-admission information for patients provided them with clear instructions on fasting times for food and fluid prior to surgery. Current guidance recommends fasting from food for six hours and fluid for two hours. Records we reviewed showed that patients had adhered to fasting times prior to surgery going ahead. However; on seven out of seven occasions we did see that staff had fasted patients for too long for example 13 hours prior to surgery. Audits on patient fasting times were not carried out within the directorate.

Protected mealtimes were promoted on the wards we visited. Red trays, were used to identify patients who required additional assistance with food of fluids.
We saw staff helping to re-position patients prior to their meal and assist them with their food. The majority of patients we spoke with said that the food was acceptable and that the water was replenished daily and as required. One patient said that there was only salad available when their operation was cancelled and they would have preferred more choice after fasting all day.

**Pain relief**

During the inspection, we saw patients being offered pain relief. Patients we spoke with said that staff offered them pain relief at regular occasions and that staff checked that pain relief administered had been effective.

We observed staff using pain scoring tools to assess patients’ levels of pain, staff recorded this information on the electronic records system. Some surgical patients received intravenous patient-controlled pain relief post-operatively. This was in line with national best practice guidance from the British pain society.

The majority of patients we spoke with said that staff responded in a timely way when they needed pain relief, only one patient had experienced a delay. Nursing staff we spoke with said that there was a trust pain team, to support patients in pain, we saw evidence of one patient accessing this service.

**Patient outcomes**

**Trust level**

From November 2016 to October 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

All of the top three elective specialties at the trust, based on count of activity (urology, colorectal surgery and ophthalmology), had a lower expected risk of readmission when compared to the England average.

All patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

All the top three non-elective specialties at the trust, based on count of activity (general surgery, trauma and orthopaedics and urology), had a lower expected risk of readmission when compared to the England average.

**Elective Admissions – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
</tr>
</tbody>
</table>

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

**Non-Elective Admissions – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
</tr>
<tr>
<td>Orthopaedics</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
</tbody>
</table>
Scunthorpe General Hospital

From November 2016 to October 2017, all patients at Scunthorpe General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Two of the top three elective specialties at the hospital, based on count of activity (urology and colorectal surgery), had a lower expected risk of readmission when compared to the England average. General surgery had a higher expected risk of readmission.

All patients at the hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Two of the top three non-elective specialties at the hospital, based on count of activity (general surgery and urology, had a lower expected risk of readmission when compared to the England average. Trauma and orthopaedics had a higher expected risk of readmission.

Elective Admissions - Scunthorpe General Hospital

Non-Elective Admissions - Scunthorpe General Hospital
Hip Fracture Audit

Scunthorpe Hospital

In the 2017 National Hip Fracture Database audit, the risk-adjusted 30-day mortality rate was 7.5% which was within the expected range. The 2016 figure was 6.0%.

The proportion of patients having surgery on the day of or day after admission was 53.5%, which was in the bottom 25% of hospitals and did not meet the national aspirational standard of 85%. The 2016 figure was 62.5%.

The perioperative medical assessment rate was 75.8%, which was in the bottom 25% of hospitals and did not meet the national aspirational standard of 100%. The 2016 figure was 80.8%.

The proportion of patients not developing pressure ulcers was 97.7% which falls in the middle 50% of hospitals. The hospital did not meet the national aspirational standard of 100%. The 2016 figure was 100%.

The length of stay was 14.5 days which was in the top 25% of hospitals. The 2016 figure was 12.6 days.

(Source: National Hip Fracture Database 2017)

We first highlighted the deteriorating position in relation to the national hip fracture database audit at the 2014 inspection, and requirement notices had been issued at each subsequent inspection. At this inspection, we reviewed action plans and discussed with staff including the senior management team why improvements had not been seen in the proportion of patients having surgery on the day or the day after admission. We heard a variety of reasons including, theatre utilisation, case prioritisation, emergency theatre refurbishment and patients not being clinically well enough for surgery. We acknowledged that the emergency theatre had recently been refurbished and this could have impacted on the availability for trauma surgery to be performed, however as most of the trauma surgery was carried out on the dedicated trauma list in a different theatre, refurbishment alone was not the only reason for delays.

Records we reviewed showed that 20 out of 40 patients reviewed were not able to access theatre on the day of or the day after admission. This was for a variety of occasions including lack of theatre time (11/40 cases), treatment delays and stabilisation of cases pre-operatively (9 cases).

We acknowledged on occasions patients can be too unwell to access theatre at the point of admission, however staff we spoke with highlighted on occasions patients were being delayed because of staff following best practice guidance in relation to anti-coagulant medication. Staff we spoke with all highlighted that access to emergency theatres was not seven days a week and this led to delays, they also said that delays occurred due to other non-emergency patients being placed on the trauma list. For example; traumatic shoulder or knee injuries waiting for shoulder and knee specialist doctors were listed and operated on prior to fractured neck of femur patients.

Non-compliance with hip fracture audit and best practice recommendations was highlighted on the directorate’s risk register at the time of the inspection. The action plan from the 2017 audit included a review of local data to identify and target common avoidable clinical and organisational reasons for delay in surgery, this was due for completion by June 2018.

Bowel Cancer Audit
In the 2017 National Bowel Cancer Audit, 87.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 89%.

The risk-adjusted 90-day post-operative mortality rate was 4.5% which was within the expected range. The 2016 figure was 6.9%.

The risk-adjusted 2-year post-operative mortality rate was 23.9% which was within the expected range. The 2016 figure was 22.7%.

The risk-adjusted 30-day unplanned readmission rate was 10.5% which was within the expected range. This figure was not reported in 2016.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 63.2% which was worse than expected. The 2016 figure was 59.3%.

(Source: National Bowel Cancer Audit)

At this inspection, we reviewed action plans and saw that all actions had been completed in April 2018 and that issues of concern from the report had been identified and actions taken to improve performance.

Oesophago-Gastric Cancer National Audit

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.6%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 23.2%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.3% which was significantly lower than the England average.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

At this inspection, we reviewed action plans for the trust and saw that the action plans addressed issues of poor performance within the report including the number of emergency admissions; 23.1% of patients diagnosed after an emergency admission compared to the national result of 13.7%. This was the second consecutive year that the trust had worse than national outcomes. The directorate had agreed to an investigation of the cases diagnosed after admission to understand the reasons for this and to improve performance.

The trust also performed worse than the national average for newly diagnosed oesophago-gastric cancer patients having a staging CT scan to enable the doctor to investigate the extent to which the disease has spread. The directorate had agreed to review these patients and learn lessons to improve performance.

National Emergency Laparotomy Audit

Scunthorpe General Hospital

In the 2017 National Emergency Laparotomy Audit (NELA), the hospital achieved a red rating for
the crude proportion of cases with pre-operative documentation of risk of death, indicating that less than 50% of patients met this criterion. This was based on 78 cases.

The hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames, indicating that between more than 80% of patients met this criterion. This was based on 43 cases.

The hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre, indicating that between 50% and 80% of patients met this criterion. This was based on 51 cases.

The hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively, indicating that more than 80% of patients met this criterion. This was based on 32 cases.

The risk-adjusted 30-day mortality for the hospital was 11.8% which was within the expected range, based on 78 cases. 
(Source: National Emergency Laparotomy Audit)

At this inspection, we requested to review action plans, but these were not supplied. Following the inspection, the trust supplied this for review.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:
- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was worse for EQ VAS outcomes and about the same for EQ-5D index outcomes.

For hip replacements and knee replacements was about the same as the England average. 
(Source: NHS Digital)

At this inspection, we reviewed the directorate response to the results and noted items of positive
progress and items of concern from the audits were discussed at the quality and safety committee in March 2018.

**Competent staff**

From April 2017 to January 2018 65.7% of staff within surgery at the trust had received an appraisal compared to a trust target of 95%.

A split by site and staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff who have received an appraisal</th>
<th>Total staff required to complete appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>5</td>
<td>5</td>
<td>95%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>102</td>
<td>133</td>
<td>95%</td>
<td>76.7%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>48</td>
<td>65</td>
<td>95%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>117</td>
<td>162</td>
<td>95%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>168</td>
<td>274</td>
<td>95%</td>
<td>61.3%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>99</td>
<td>177</td>
<td>95%</td>
<td>55.9%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>0</td>
<td>4</td>
<td>95%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
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<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>2</td>
<td>2</td>
<td>95%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>50</td>
<td>64</td>
<td>95%</td>
<td>78.1%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>23</td>
<td>30</td>
<td>95%</td>
<td>76.7%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>48</td>
<td>64</td>
<td>95%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>67</td>
<td>94</td>
<td>95%</td>
<td>71.3%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>44</td>
<td>73</td>
<td>95%</td>
<td>60.3%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>0</td>
<td>1</td>
<td>95%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital had a 71.3% appraisal completion rate overall surgery with only qualified allied health professionals meeting the 95% appraisal completion target.

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*

At this inspection, we saw a decrease in the appraisal rates reported for nursing and medical staff. Staff we spoke with said they had, had a yearly appraisal, some members of staff reported that they had not had one for a couple of years prior to the recent appraisal.
Senior staff we spoke with said that they had developed extended roles for nursing staff. These are nursing staff with extended skills to support patients. For example; advanced nurse practitioners, staff had to complete additional training and competence qualifications to allow them to undertake these roles.

Within theatres, staff had specific roles with additional training to allow them to train other staff, for example; blood training, adult life support and specialist equipment. Theatre staff had commenced updating competence booklets for staff working in theatres.

It was not clear within pre-assessment what level of training and competence was required to enable staff to pre-assess patients prior to surgery, staff we spoke with said that staff from the day case unit rotated into the clinic to improve staffing levels.

Newly recruited staff completed most of their mandatory training at an induction programme called ‘Care Camp’. This was an intensive two-week education programme to ensure that all staff received the same training and had been operating since 2015.

Registered staff we spoke with that they had been supported through revalidation by the trust.

**Multidisciplinary working and coordinated care pathways**

There was established multidisciplinary team (MDT) meetings for discussion of patients on specific pathways or with complex needs, this included attendance from consultants, specialist nurses and radiologists. We attended a multidisciplinary trauma and handover meeting and saw good attendance and appropriate discussion. Staff held multidisciplinary safety huddles on the wards we visited.

Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.

**Seven-day services**

The orthopaedic trauma list was only delivered over six days, this meant that patients who required surgery Friday evening and Saturday had to wait till the Sunday morning to have their operation. If space was available orthopaedic patients could be placed on the emergency theatre list, however this was on a minority of occasions. This had been identified as an issue previously in regional trauma service reports.

At the time of the inspection, junior medical staff were available seven days a week with support from senior doctors and consultants. Surgical consultants provided a seven-day week service.

Staff had access to therapy support seven days a week, however physiotherapy staff were only available on a Sunday to review unwell patients, or patients being discharged. A business case had been developed to provide orthopaedics with therapy staff seven days a week.

The trust pharmacy and diagnostic imaging department provided seven-day a week services

The trust dietetic department offered a Monday to Friday service.

**Access to information**

Staff we spoke with informed us that they could access the trust’s policies through ‘The Hub’; i.e. the intranet.
Staff we spoke with said that they could access patient records out of hours by ringing the filing clerks to bring patient records on to the wards.

Staff we spoke with said test results could be accessed through the online patient management system. This was password protected and staff had different levels of access depending on their grades. Only doctors could access x-rays and scans through the system. Nursing staff could only access scan reports.

**Health promotion**

Health promotion information was available on all wards we visited. This included display boards and information leaflets. We saw information on smoking cessation, healthy eating, drugs, alcohol and housing needs.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards. We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

The Mental Capacity act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, were someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests. Staff we spoke with could give a clear explanation of capacity assessment and the importance of recognising how ill health can impact on patient’s capacity. Staff also said that support was available from the safeguarding team if an urgent authorisation for a deprivation of liberty was needed for a patient who lacked capacity. We saw one patient undergoing surgery when this procedure had been used, there was clear documentation of discussion and the specific consent form four had been used correctly.

We spoke with eight members of staff across four surgical wards. All the staff were knowledgeable what they would do if a patient lacking capacity. Staff explained that mental capacity assessment would be conducted by trained staff on the ward. This would involve a two-stage assessment process including a memory test, if the patients were classed as high risk, an automatic alert was sent to the living with dementia team.

At the 2016 inspection, we said that the trust must ensure that a patient’s capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the Mental Capacity Act (2015). At this inspection, we reviewed four records specifically for evidence of mental capacity assessments and we found this was completed in all four sets.

We also said that the trust should ensure that staff complete Mental Capacity Act training. At this inspection we saw that compliance was below the trust own target with 55% medical and dental staff and 77% of nursing staff completing training. Staff we spoke with informed us that they had completed Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLs) training either as part of their mandatory training.

(Source: Trust Provider Information Request P14/P49)

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person’s best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are Deprivation of Liberty Safeguards (DoLs). DoLs can
only be used if the person will be deprived of their liberty in a care home or a hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards. We did not see any patients with DoLs authorisations. This is unusual in hospitals of this size and speciality.

Staff we spoke with said they had access to mental health referral pathways and they would use these with any patients they had concerns about.

We saw that where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were stored at the front of the care records in line with national best practice. We did not see any ReSPECT documentation in use. ReSPECT is a process that creates personalised recommendation for a person’s clinical care in a future emergency in which the patient is unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.

**Is the service caring?**

**Compassionate care**

We spoke with 25 patients on the surgical wards at this hospital. On the majority of occasions patients we spoke with were happy with their care.

In wards and departments, we visited we observed staff caring for patients and found that they were compassionate and reassuring. We heard staff introducing themselves by name and explaining the care and treatment they were delivering.

A patient we spoke with said that they “couldn’t fault the service and throughout their stay they had been treated with dignity and respect”.

One patient we spoke with said that they were happy staff had a “sense of humour” and that the ward was “brilliant” and that staff were “encouraging”. Another patient said that it was like a “holiday” and they felt safe and well looked after.

On ward 10 we saw staff allowed open visiting to a patient’s relative, due to the patient being unwell.

Patients we spoke with said that staff answered buzzers quickly and during the inspection we did not hear buzzers ringing for long periods of time.

We observed staff closing curtains and doors whilst delivering personal care.

Wards and departments, we visited displayed their friends and family results. The Friends and Family Test (FFT) response rate for surgery at Northern Lincolnshire and Goole NHS Foundation Trust from December 2016 to November 2017 was 23% which was worse than the England average of 29%. A breakdown of response rate by site can be viewed below.
Friends and family test response rate at Northern Lincolnshire and Goole NHS Foundation Trust, by site.

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Day cases</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dec-16</td>
</tr>
<tr>
<td>Ward 10</td>
<td>51</td>
<td>10%</td>
<td>780</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 11</td>
<td>68</td>
<td>9%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Ward 25</td>
<td>550</td>
<td>31%</td>
<td>92%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 28</td>
<td>187</td>
<td>11%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

Emotional support

We saw that ward managers were visible on wards and departments we visited, and patients and relatives could speak with them.

We heard a conversation between a patient and nursing staff and heard nursing staff providing comfort and support.

Patients we spoke with said that staff were available to talk to them as required.

A multi-faith chaplaincy service was available for patients.

Clinical nurse specialists were available within surgery and attended wards to provide additional support and advice to patients.
Understanding and involvement of patients and those close to them

A range of information leaflets and advice posters were available on wards we visited these included discharge information, specialist services and general advice about their care and treatment.

The majority of patients we spoke with said that staff took time to explain their care and they were aware of their plans of care. Two patients we spoke with said they didn’t feel involved in their care and felt that staff had not explained everything to them.

Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions.

One patient spoke with us about their operation to “going as per plan” they were pleased that post-operatively a member of the medical team had spoken with them and explained why it had changed.

On ward 25, the main complaint patients said to us where that they were being asked to move wards and they did not want to move as they were happy with the care being provided.

Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.

Is the service responsive?

Service delivery to meet the needs of local people

The surgery directorate provided elective (planned) and non-elective (acute) surgical treatments for patients.

The directorate had improved collaborative working with commissioners and now had commissioners on key groups within the directorate to plan and deliver services.

The directorate had recently made a decision to move the majority of elective orthopaedic surgery to Goole and District Hospital to improve performance and patient outcomes.

Meeting people’s individual needs

At the 2016 inspection, we said the trust must monitor and address mixed sex accommodation breaches. At this inspection, NHS England had relaxed the requirements around mixed sex accommodation for all NHS providers to ease winter pressures. During this inspection, we did see male and female patients located next to each other in high observation areas. The trust said this had been agreed with commissioners.

Staff used ‘this is me’ documentation for patients living with dementia or learning disabilities. Patients living with dementia were identified to staff by a butterfly symbol to enable them to provide additional support.

The trust employed a learning disabilities nurse, staff we spoke with knew how to access this service and said that this service was responsive.

We reviewed patient led assessments of the care environment (PLACE) reports for 2017 and noted 63% compliance for how well the needs of patients with dementia were met. This was worse than the 77% England average. Compliance was also worse 70% (83% England average) for how
well the needs of patients with disability were met and compliance for privacy, dignity and
wellbeing provision was 77%. This was worse than the 84% England average.

Patients we spoke with said that staff respected their privacy and dignity by closing curtains and
doors as necessary.

The pre-assessment teams or the admitting wards identified patients’ needs such as hearing, sight
or language difficulties. Translation services were available for patients whose first language was
not English. Staff we spoke with knew how to access these services. Staff we spoke with said this
service was responsive.

Patients were provided with information leaflets on topics such as blood transfusion, Parkinson’s
disease. The leaflets were in English and staff informed us they would contact PALS for leaflets in
other languages.

Patients with additional care needs were identified at handovers and safety huddles for example
patients living with dementia, learning disabilities or mental health conditions.

Wards and departments were accessible for patients with limited mobility and people who use a
wheelchair. Specialised equipment for bariatric patients was available on some wards visited.

Access and flow

At the 2016 inspection, we saw that the directorate did not have in place systems to ensure the
capacity of services were sufficient to meet the demands. We saw that patients could not access
services for assessment, diagnosis or treatment in a timely way. The service had long wait times
and overall it did not meet referral to treatment pathways. At this inspection we saw worsening
waiting times.

The service had started to identify capacity and demand for the service with the NHS improvement
intensive support team.

Referral to treatment (percentage within 18 weeks) - admitted performance

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted
pathways for surgery was generally slightly lower than the England average. Over the 12-month
period the trust’s performance ranged from 61% to 69% and in the most recent month (December
2017) the 65% of patients were treated within 18 weeks from time of referral which was lower
than the England average of 72%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of RTT rates for surgery broken down by specialty is below. Of these two
specialties were above the England average:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>80.9%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>72.9%</td>
<td>64.5%</td>
</tr>
</tbody>
</table>

Four specialties were below the England average:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>70.1%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>61.1%</td>
<td>72.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>58.0%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>52.3%</td>
<td>61.4%</td>
</tr>
</tbody>
</table>

**Trust Level – elective patients**

From November 2016 to October 2017, the average length of stay for all elective patients at the trust was 3.5 days, which was similar to the England average of 3.9 days.

Two out of the top three specialties at the trust (based on count of activity) had an elective length of stay similar to the England average (trauma and orthopaedics and urology) and one specialty had a lower elective length of stay than the England average (colorectal surgery).

**Elective Average Length of Stay – Trust Level**

Note: Top three specialties for specific trust based on count of activity.

**Trust Level – non-elective patients**

From November 2016 to October 2017, the average length of stay for all non-elective patients at the trust was 5.2 days, which was similar to the England average of 5.0 days.

Two out of the top three specialties at the trust (based on count of activity) had a higher non-elective length of stay than the England average (general surgery and urology) and one specialty had a lower non-elective length of stay than the England average (trauma and orthopaedics).

**Non-Elective Average Length of Stay – Trust Level**
Scunthorpe General Hospital - elective patients

From November 2016 to October 2017, the average length of stay for all elective patients at Scunthorpe General Hospital was 3.5 days, which was similar to the England average of 3.9 days.

All three of the top specialties at the trust (based on count of activity) had an elective length of stay similar to the England.

Elective Average Length of Stay - Scunthorpe General Hospital

The trust had recently moved a number of elective orthopaedic procedures to be performed at Goole and District Hospital, rather than at Scunthorpe to improve performance. The directorate had a plan to move 70% of eligible elective orthopaedic surgery to Goole by the end of 2018.

Scunthorpe General Hospital - non-elective patients

From November 2016 to October 2017, the average length of stay for all non-elective patients at Scunthorpe General Hospital was 4.6 days, which was similar the England average of 5.0 days.

Two out of the top three specialties at the hospital (based on count of activity) had a higher non-elective length of stay than the England average (general surgery and urology) and one specialty had a lower non-elective length of stay than the England average (trauma and orthopaedics).

Non-Elective Average Length of Stay - Scunthorpe General Hospital
We saw a worsening position in patients waiting longer than 52 weeks for surgical treatment this had deteriorated from 131 patients January 2018, to 324 patients March 2018.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From January 2016 to December 2017 the percentage of patients whose operation was cancelled and were not treated within 28 days increased over time, but in six out of eight quarters the trust performed better than the England average. In the most recent quarter (Q3 2017/18) 5% of patients whose operation was cancelled were not treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Northern Lincolnshire and Goole NHS Foundation Trust**

**Cancelled operations as a percentage of elective admissions - Northern Lincolnshire and Goole NHS Foundation Trust**
From January 2016 to December 2017 the percentage of cancelled operations at the trust improved from Q3 2016/17 to Q4 2016/17 before deteriorating for the remaining reporting period. The trust generally performed similar to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

At the 2016 inspection, we saw that a high number of patients were cancelled for clinical and non-clinical reasons. Non-clinical cancellations were usually because of the lack of availability of surgical beds, cancellations for clinical reasons were usually because of in-effective pre-assessment of patients or patients had deteriorated pre-operatively. At this inspection we saw that within the directorate from January to April 2018, 318 patients had their surgery cancelled for non-clinical reasons, an average of 79 patients a month. We acknowledged the NHS England national winter pressures directive which was to cancel elective activity and focus on emergency care. However, we saw that 308 patients had their surgery cancelled for clinical reasons, an average of 77 patients a month over the same period. A number of patients we spoke with said that they had had their previous dates for surgery cancelled and had to wait a few months for this to be rescheduled.

We reviewed theatre usage and saw that out of 2,120 planned theatre sessions available within the directorate January to April 2018, 1,992 sessions were delivered.

During the inspection, we saw a number of surgical wards had medical patients (outliers) located on them. The number of outliers affected the number of beds available for surgical patients. The surgical management team recognised the issues of capacity and demand and balanced this with concerns over staffing levels. They had recently commenced bed modelling plans to ensure that services were delivered in an improved way and had recently moved some services to only be provided on a single site to improve staffing levels and clinical outcomes. The management team recognised that this work needed to be extended to other services and include the provision of medical beds.

**Learning from complaints and concerns**

The trust had a process that addressed both formal and informal complaints that were raised by patients or relatives.

From 7 February 2017 to 7 February 2018 there were 131 complaints about surgery.

The trust took an average of 51 working days to investigate and close complaints. The trust had three targets for closing complaints. The trust had a target to close complaints within 30 working days and a further target of 45 working days. Only 24% of all closed complaints in surgery were closed in 30 working days and 34% of closed complaints were closed within 45 working days.
The trust had a target to close more complex complaints within 60 working days. Only 63% of all closed complaints (complex and non-complex) were closed within this target.

The most common subjects complained about in surgery were:
- Patient care - 68 complaints (51.9%)
- Appointments - 11 complaints (8.4%)
- Admissions and discharges (excluding delayed discharge due to absence of care package) - 11 complaints (8.4%)
- Communications - 11 complaints (8.4%)

Scunthorpe General Hospital

From 7 February 2017 to 7 February 2018 there were 53 complaints about surgery at Scunthorpe General Hospital.

The trust took an average of 48 working days to investigate and close complaints. Only 32% of all closed complaints in surgery were closed in 30 working days and 46% of closed complaints were closed within 45 working days.

Only 68% of all closed complaints (complex and non-complex) were closed within the target.

The most complained about subjects at this hospital for surgery were:
- Patient care – 25 complaints (47.2%)
- Appointments – eight complaints (15.1%)
- Access to treatment or drugs – seven complaints (13.2%)
- Communications – six complaints (11.3%).

We saw information displayed in ward areas about how to complain or raise a concern. Staff we spoke with could describe how they would respond to a complaint or a concern was raised.

Staff we spoke with said that themes and trends of complaints were shared with staff at ward huddles, meetings and individual conversations. The clinical director said that themes and trends of complaints were discussed at the directorate clinical governance meetings, we reviewed three sets of governance minutes and one set of governance oversight minutes saw discussion about the numbers of complaints and concerns raised within the directorate.

Is the service well-led?

Leadership

In 2016 we saw that there had been a number of changes in the surgical senior management team and senior nurses within surgery had also changed roles and others were new in post. We said that these teams required further time to develop and become fully effective in their roles. Since the last inspection, the senior management team had undergone further changes and at the time of the inspection, one of the team was interim.

Over the last year the trust had changed divisional structures to improve clinical oversight and governance within directorates. The senior management team within surgery had been restructured, clinical directors had been appointed and had oversight of the directorate, they were supported by an operational director and operational chief nurse. Staff we spoke with said the senior management team was supportive and visible on the wards and departments, they also said that the executive team were not visible.
Staff felt supported by their managers and colleagues at ward level. Staff we spoke with said that they found some of the site management team unsupportive and some staff described a ‘bullying approach’. They said that this was often in relation to taking what they classed as unsuitable outliers or because of expressing concern about their staffing levels. We discussed this with the senior management team who were aware of the issue and had started improved communications to improve the issues.

We found ward managers on the wards and departments we visited knowledgeable and professional. They appeared visible and approachable for junior members of staff they supported.

Ward managers were allocated dedicated time for management and support of staff, however due to staffing and skill mix ward managers were still expected to care for a cohort of patients whilst undertaking co-ordinator roles. This meant that ward manager had to prioritise work to enable patient care not to be compromised, this often led to them working additional hours or working in their free time to complete management tasks.

Junior medical staff said that they felt supported by senior colleagues.

**Vision and strategy**

The trust had a mission statement however this had not been developed in conjunction with staff and staff we spoke with were not able to articulate this statement, the strategic plan for the surgical directorate or the values of the trust.

At the 2016 inspection, the clinical strategy did not refer to national reports and recommendations, the values or strategy of the trust or refer to appropriate deadlines for completion. At this inspection, we requested to review the strategy but as the trust was in the process of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the surgical service for 2018/2019.

The directorate was reviewing different ways of delivering services due to recruitment issues. These included advanced nurse practitioners, advanced care practitioners and doctor assistants. Some of these staff had commenced training and some had yet to be agreed.

**Culture**

At the 2016 inspection, we said that the trust must ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions. At this inspection, staff we spoke with said that they had started to see improvements in the culture of the trust since changes in the trust’s leadership team.

Staff we talked with said they said they felt valued by their patients, ward leaders and the trust. They said that morale was variable within the wards and departments.

The senior management team were proud of staff working within the directorate and their resilience during ‘winter pressures’.

**Governance**

The directorate had changing governance structures. The clinical director was a member of the trust management board and although a new structure, the management team felt that this had improved communication within the directorate. The directorate had also set up a surgical management board which was attended by all clinical leads and the senior management team said this had a greater degree of clinical focus. Each speciality had business meetings which escalated issues of concern to the overall surgical business meeting. We reviewed three sets of
meeting minutes and saw evidence of discussions about complaints, serious incidents and other operational updates, however we did not see discussion about risk registers, financial issues or themes of incidents, however the directorate board meetings did contain this information.

The current governance structures were in their infancy within the directorate and currently provided low-levels of assurance against safety performance, from board to ward. The surgical management team acknowledged that governance needed to be strengthened within the directorate especially oversight of mortality, they also acknowledged that they required a further period of embedding to be fully effective. We reviewed minutes from directorate transformation board, governance committees, governance oversight boards and directorate board meetings these did include some discussion about risk and incident themes and actions and business updates. But these reports did not include issues for upward reporting or learning or evidence of celebrating success and good news.

The surgical directorate transformation plans were based on the getting it right first time (GIRFT) methodology, this is a programme to improve efficiencies and clinical quality in the NHS, by reducing variations. Transformation boards and meetings had been developed within all specialties. Minutes we reviewed showed that key actions had been identified and these issues had been rag rated, however from reviewing the plans and meeting minutes we did not see oversight of recovery plans, or discussion of the current number of patients awaiting appointments or clinical validation. Following the inspection, the senior management team said that this oversight was at the business meetings and surgical board meeting.

**Management of risk, issues and performance**

The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services.

At the 2016 inspection, we said that the trust must ensure that service risk registers are regularly reviewed, updated and included the majority of relevant risks to the service. The directorate had a risk register which highlighted current risks and documented mitigating actions to reduce the risks. Data we reviewed showed that there were currently 48 risks with 22 currently rated as high risks, 14 medium risks and 12 low risks following identification of mitigating actions. These risks were reviewed at the monthly governance oversight meeting but in the minutes, we were supplied with we did not see evidence of discussion or escalation of these risks to executive boards. The senior management team spoke with us that these were new processes that required further time to be fully embedded. Following the trust supplied further information providing assurance that escalation if risks from the service were highlighted to the quality and safety board.

Following the inspection, the trust supplied further information providing assurance that escalation of risks from the service were highlighted to the quality and safety board.

We discussed with senior staff within the directorate about their highest risks, they identified staffing, performance, capacity, finance and pressure area management these risks were identified on the risk register.

At the 2016 inspection, we did not see that the directorate had clear up to date recovery plans to recover referral to treatment times. At this inspection, we saw that each speciality had transformation plans including recovery and decisions had been made to provide services on one site to improve patient safety and outcomes for example; ear nose and throat services, urology services. Some transformation plans were still in their infancy and key actions, outcomes and mitigation had yet to be fully identified and developed.

The directorate had not moved with pace to implement fully effective and consistent pre-assessment procedures. We did see some improvements in the service offered to patients in
terms of increased capacity, staffing and educational developments but this required more embedding to be fully effective and responsive.

At the 2016 inspection, we highlighted that compliance with the number of patients with fractured neck of femurs receiving surgery on the day or the day after admission had not improved significantly and there was no clear reason for the lack of improved performance. At this inspection, we again saw a deteriorating trend of performance and it was clear from discussion with staff working within the directorate that there was no clear oversight of the issue. Action plans did not always address the issues identified within the reports and did not reflect improvements seen at the Diana Princess of Wales hospital and ensure these were mirrored at SGH for example employment of a fracture liaison nurse and improved theatre access. The lack of pace to improve the issues did not provide assurance that performance would improve. Following the inspection, the senior management team said that the trust had improved oversight and now had daily updates on trauma numbers, re-instated the hip fracture governance meetings and had a commitment and drive to improve performance.

We saw variable performance in other national audits. Action plans we reviewed addressed issues identified within the reports but had not had an impact on overall performance outcomes.

**Information management**

Information provided by the trust, showed that 77% of medical and dental staff and 82% of nursing staff had completed information governance training. Medical staff rates were worse than the trust’s target level of training of 85%, with nursing staff rates being above the 85%.

We did not have any concerns during the inspection about the security of patient records.

Computers were available on surgical wards. During the inspection, all computers were locked securely when not in use.

**Engagement**

At the 2016 inspection, we said the trust should review the formal feedback process in place to collect patient or relative feedback. We also said that the trust should take steps to improve its staff and public engagement activities. At this inspection, we saw that patient representatives were now included in key committees within the directorate.

During the inspection we saw you said we did display boards these showed changes of practice in relation to patient feedback for example; improved written communication pre-operatively.

Staff we spoke with said that changes in practice had been implemented as a result of patient feedback, these included reviewing fasting information for surgical patients.

**Learning, continuous improvement and innovation**

The trust held a celebrating success award ceremony, a number of surgical staff had been nominated and won awards.

The trust was an early adopter of the NEWS two pathway, which provides improved safety and clinical outcomes for acutely ill patients.
Facts and data about this service

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of maternity services for women at all three of the acute hospital sites.

At Diana, Princess of Wales Hospital, Grimsby, maternity services are provided within a dedicated, custom made family services building. The service offered is an LDRP (Labour, Delivery, Recovery and Postnatal) system of care; which allows a woman to labour and deliver in the same en-suite room. The unit houses a dedicated operating theatre, a family room, a high dependency room, a room for disabled mums-to-be and a water-birth room.

At Scunthorpe General Hospital, Scunthorpe maternity services are provided on ward 26 and the Central Delivery Suite. Ward 26 is a mixed antenatal and postnatal ward where midwives provide care for women having inductions of labour, observations for complications and women resting following the birth of their baby. The ward also offers transitional care. The central delivery suite incorporates a dedicated obstetric theatre and has a birthing pool.

At Goole and District Hospital, Goole, the hospital offers daily antenatal midwife led clinics with a weekly obstetric clinic, there is also a midwifery led birthing suite onsite. The birthing suite is in within the grounds of the hospital though there are no other inpatient obstetric or neonatal services. Labour care is therefore provided to women booked for midwifery led care only in a ‘home away from home’ setting. The unit serves the East Riding area and has a delivery bed and birthing pool. Women who are classed as “high risk” are transferred to Scunthorpe for delivery.

The trust has 72 acute maternity beds located across six wards; four wards at Diana, Princess of Wales hospital and two at Scunthorpe General hospital.

Diana, Princess of Wales Hospital:
- Jasmine ward – nine beds
- Blueberry ward – nine beds
- Holly ward – nine beds
- Honeysuckle ward – ten beds

Scunthorpe General Hospital:
- Central delivery suite – eight beds
- Ward 26 – 27 beds

(Source: Trust Provider Information Request – Acute sites and context, Trust website)

From October 2016 to September 2017, there were 4,194 deliveries at the trust.

The graph below is the number of babies delivered at the trust in comparison with other trusts in England:
A profile of all deliveries and gestation periods from July 2016 to June 2017 can be seen in the tables below:

### Table 1: Profile of all deliveries (October 2016 to September 2017)

<table>
<thead>
<tr>
<th></th>
<th>NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Single or multiple births</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4,130</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>64</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother's age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>240</td>
<td>5.7%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,398</td>
<td>81.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>473</td>
<td>11.3%</td>
</tr>
<tr>
<td>40+</td>
<td>83</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,194</td>
<td></td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

Comparatively more woman under 20 years of age (5.7%) and between the ages of 20 and 34 years (81%) gave birth at the trust compared to England averages; 3.1% and 75.1% respectively.

### Table 2: Gestation periods (October 2016 to September 2017)

<table>
<thead>
<tr>
<th></th>
<th>NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td><strong>Gestation period</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3
Under 24 weeks | * | * | 0.2%
Pre-term 24-36 weeks | 240 | 6.8% | 7.8%
Term 37-42 weeks | 3,272 | 93.0% | 91.8%
Post Term >42 weeks | * | * | 0.2%

Total number of deliveries with a valid gestation period recorded
Total | 3,518 | 498,097

Notes: To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with "*" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The gestation period of babies born at term (between 37 and 42 weeks) was 93.3%. This was above the England national average (91.8%).

Is the service safe?

Mandatory training
The trust set a target of 85% for completion of mandatory training. They were not meeting their target overall in both medical and nursing/midwifery staff groups.

The table below shows the trust wide, overall mandatory completion rates (we received from the trust on the 11 June 2018).

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>59</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>79</td>
</tr>
</tbody>
</table>

The governance midwife was responsible for coordinating the training of maternity services workforce across the trust. This was to ensure the development and delivery of successful clinical care.

Information provided by the trust showed mandatory training figures were collated monthly, discussed at monthly performance meetings and all managers had oversight. The information was submitted to the trust board in the monthly staffing report.

Mandatory training completion rates
A breakdown of compliance for mandatory courses from February 2017 to January 2018 for medical staff is shown below:

Mandatory training - medical staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>
The overall mandatory training completion rate for medical staff in maternity was 56% at Scunthorpe General Hospital. This was below the trust target of 85%.

Mandatory training for the medical staff was the responsibility of individuals to book themselves onto the trust mandatory training. The divisional clinical director monitored this. The Governance midwife confirmed not all the clinical staff were up to date with their training. They also provided evidence to show the staff were reminded to attend the training.

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for qualified nursing and midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>12</td>
<td>17</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>12</td>
<td>17</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>9</td>
<td>17</td>
<td>53%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>7</td>
<td>17</td>
<td>41%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>7</td>
<td>17</td>
<td>41%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>6</td>
<td>17</td>
<td>35%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>95</strong></td>
<td><strong>170</strong></td>
<td><strong>56%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for nursing and midwifery staff in maternity was 83% at Scunthorpe General Hospital. This was below the trust target of 85%.

At this location the trust target was met in five out of ten modules.

(Source: Routine Provider Information Request (RPIR) - Mandatory training)

A breakdown of compliance for mandatory training courses from February 2017 to January 2018, for qualified community midwifery staff within the Scunthorpe and Goole teams are shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>95</td>
<td>97</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>87</td>
<td>97</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>86</td>
<td>97</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>86</td>
<td>97</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>82</td>
<td>97</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>80</td>
<td>97</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>78</td>
<td>96</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>74</td>
<td>97</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>73</td>
<td>97</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>63</td>
<td>97</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>804</strong></td>
<td><strong>969</strong></td>
<td><strong>83%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>
### Name of course | Number of eligible staff (YTD) | Number of staff trained (YTD) | Completion rate | Trust Target | Met (Yes/No)
--- | --- | --- | --- | --- | ---
Manual Handling - Object | 22 | 22 | 100% | 85% | Yes
Resuscitation | 20 | 22 | 91% | 85% | Yes
Conflict Resolution | 18 | 22 | 82% | 85% | No
Manual Handling - People | 18 | 22 | 82% | 85% | No
Slips, Trips & Falls | 18 | 22 | 82% | 85% | No
Equality and Diversity | 17 | 22 | 77% | 85% | No
Fire Safety 2 years | 17 | 22 | 77% | 85% | No
Information Governance | 17 | 22 | 77% | 85% | No
Infection Control - 1 Year | 13 | 22 | 59% | 85% | No
PREVENT Level 1 | 11 | 22 | 50% | 85% | No
**Grand Total** | **171** | **220** | **78%** | **85%** | **No**

Mandatory training information we received about community midwifery staff from February 2017 to January 2018, showed an overall compliance rate of 73% across the trust. This was below the trust target of 85%. The only training module to exceed the trust's target was for manual handling object (98%). Compliance rates for equality and diversity and resuscitation training both fell slightly short of target (at 84% each).

Mandatory training information we received about community midwifery staff from February 2017 to January 2018, showed an overall compliance rate of 78% for Scunthorpe and Goole based midwives. This was below the trust target of 85%.

Data showed that, overall the (Scunthorpe General Hospital and Goole and District Hospital) community midwives, exceeded trust completion targets for manual handling object (100%) and resuscitation (91%) training. Completion targets fell slightly short of target for conflict resolution, manual handling people, and slips, trips and falls training (at 82% each).

The trust provided updated mandatory training compliance data in March 2018, for maternity specific staff groups and by site. This showed the proportion of staff that had completed maternity specific mandatory training modules (a maximum of 26 training courses). Data for Scunthorpe General Hospital included compliance rates for the following groups:

- Maternity Antenatal Unit (97%)
- Maternity Central Delivery Suite (82%)
- Maternity Ward 26 (postnatal ward) (70%)
- Maternity Ward Pregnancy Assessment Unit (92%)
- Midwifery Breast Feeding Support (90%)
- Community Midwifery Team (75%)

The average compliance rate for maternity specific mandatory training was 84.3% across the midwifery teams listed. Excluding the community midwifery team, the overall compliance rate was 86.2% across the hospital-based midwifery teams listed. However, ward 26 had a compliance rate of 70% and was not meeting the trust target of 85%.

Midwives, medical staff and healthcare assistants attended an annual obstetric skills and drills training session. Data provided by the trust in May 2018, showed compliance for skills and drills training across sites was 81%. Site specific data was not provided and we did not have a trust target for this training. The training included antepartum, and post-partum haemorrhage, cord prolapse, eclampsia, shoulder dystocia, and vaginal breech. Compliance rates ranged from 80% to 83% for each emergency training module.
We spoke to the trust’s governance midwife who explained that the figures did not include ad-hoc emergency study days; and if included, the compliance rate would be considerably higher.

During our inspection, we saw the obstetric emergency study day schedule for 2018. Schedules were specific to Scunthorpe General Hospital. The information included monthly dates for skills and drills training to December 2018.

**Safeguarding**

The trust had a safeguarding policy in place. There was an up to date domestic abuse policy (due for renewal May 2019). A named individual at the trust had oversight of the policy register. We looked at the register and saw appropriate actions were in place for maternity specific documents that had expired or were approaching their review date. (Please refer to the effective section, evidence-based practice of the report.)

The safeguarding lead for the trust told us that within the safeguarding team there were two full time named nurses in child protection and just under, two full time equivalent, named midwives (three members of staff, one for each site). Four days a week a named nurse for adults and specialised nurses (who worked trust wide) supported the staff. There was also a trust level named nurse for the Mental Capacity Act (MCA) and /Deprivation of Liberty Safeguards (DoLS). The area of risk was identified in 2017 and the post established.

There was a safeguarding midwife in post at this hospital, who received protected time for monitoring and managing safeguard issues and enquiries.

Safeguarding midwives attended child protection conferences and other external multidisciplinary safeguarding meetings. The safeguarding lead for the trust told us that audits were currently being carried out to monitor attendance.

Staff we spoke with onsite knew the safeguarding reporting procedures and safeguarding themes commonly encountered; for example, those centred on substance abuse and domestic violence.

**Safeguarding training completion rates**

The safeguarding lead told us that safeguarding training was a priority for the trust. The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>12</td>
<td>17</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>12</td>
<td>17</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>6</td>
<td>17</td>
<td>35%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for medical staff in maternity at Scunthorpe General Hospital was 59%. This was below the trust target of 85%.

The overall safeguarding training completion rate for nursing and midwifery staff in maternity was 83% at trust level, which fell slightly short of the trust’s target (85%).
A breakdown of compliance for safeguarding courses from February 2017 to January 2018, for community midwives across the trust and within the Scunthorpe and Goole team are shown below:

Community midwives – trust wide:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>49</td>
<td>50</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>49</td>
<td>50</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>46</td>
<td>50</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>41</td>
<td>50</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Community midwives – Scunthorpe General Hospital and Goole and District Hospital:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>21</td>
<td>22</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>21</td>
<td>22</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>20</td>
<td>22</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>18</td>
<td>22</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for community midwifery staff was 93% at trust level.

The safeguarding training compliance rate was 91% among Scunthorpe General Hospital and Goole and District Hospital community midwives. Completion targets for safeguarding children training (level 1, 2 and 3) were surpassed. The completion target for safeguarding adults training (level 1) fell slightly short of target at 82%.

Safeguarding training for nursing and midwifery staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>90</td>
<td>97</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>90</td>
<td>97</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>78</td>
<td>97</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>76</td>
<td>97</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The safeguarding training completion rate for nursing and midwifery staff in maternity was 86% at Scunthorpe General Hospital. Scunthorpe General Hospital was the only site to achieve the trust target of 85%.
Information received from the trust described how mandatory training was collated monthly, discussed at monthly performance meetings, and submitted to the board in the monthly staffing report. In addition, all managers had access to monthly mandatory training reports for oversight.

**Cleanliness, infection control and hygiene**

In the 2017 CQC maternity survey, the trust scored 9.0 out of 10 for the cleanliness of rooms and wards; this was similar to the England average.

There had been no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within maternity services at the trust in the last 12 months.

Infection prevention training was part of the trust’s training.

We requested but did not receive infection control audit data from the trust.

We observed hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks and hand gels were located at entrances and clinical areas with signs encouraging their use.

Personal protective equipment (PPE) was available in all areas we visited and provided to staff in the community.

All areas were visibly clean. ‘I am clean’ stickers were seen on equipment and were dated and initialled to show they were clean. Disposable curtains were dated, labelled and replaced every six months, or more frequently when stained.

Single rooms were available for the isolation of patients, if needed.

**Environment and equipment**

The trust provided us with audit data of monthly resuscitation trolley checks from March 2017 to March 2018. Data showed 100% compliance at trust level, for this hospital and Diana Princess of Wales Hospital.

At this inspection, we checked adult and neonatal resuscitation equipment and found checks were completed in line with the trust policy. However, on ward 26 week commencing 15 January to 08 January 2018 the checks had been completed and not signed.

We inspected the infant resuscitative equipment cabinets in three patient rooms and found the equipment cupboards had been checked, re-stocked following use and the cupboards were sealed with a tag to indicate they were ready to use.

In line with the Home Birth Guidelines, (review date, November 2020) midwives had access to the equipment they would use for a home birth.

Community midwifery staff told us and we saw that they checked and signed each shift to show they had checked the equipment they had used, and were competent to use it. This included bariatric scales, and portable suction.

Staff in the hospital and community told us that the dopplers did not require electrical testing. All portable, electrical equipment should be tested in line with manufactures instructions. The trust provided data that showed eight sonicade dopplers within the trust were tested for ‘preventative
maintenance’ from April 2016 to June 2017. An additional nine sonicade fetal dopplers were tested between January 2016 and January 2018. No additional data was provided.

Assessing and responding to patient risk

Midwifery staff identified women at high risk by using an early warning assessment tool, known as the maternity early warning score (MEWS). This was to assess the health and wellbeing of women identified as being at risk. The assessment tool enabled staff to identify and respond with additional medical support where needed.

A review of the maternity service took place in June 2017, and included the CCG, Healthwatch and staff from the trust. Findings stated that notes reviewed by the clinical representative from the CCG did not provide assurance to recognise and escalate deteriorating patients appropriately.

As a result of the review, a MEWS action plan and update was submitted to the Directorate Governance Group every month. The plan listed 14 actions, the leads for each, timescale and evidence of completion. Most of the actions had been completed.

Weekly MEWS audit data from 02 January to 21 May 2018, showed appropriate clinical escalation, and 100% compliance from 10 April 2018.

Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in obstetric theatres an adaptation of the World Health Organisation (WHO) surgical safety checklist. The records we inspected contained completed checklists. Trust audit data showed from January to April 2018, 93% compliance across the trust and 92.8% compliance at this location for completion of the checklist.

NICE guidance recommends as a minimum, intrapartum fresh eyes evaluation and documentation every hour, and by a ‘fresh pair of eyes’ every 2–4 hours (Intrapartum Care: Care of Healthy Women and Their Babies During Labour. NICE Clinical Guideline 55).

Audit data provided by the trust showed from May 2017 to March 2018, there was 96.6% compliance with ‘intrapartum fresh eyes’ across maternity services at the trust. This hospital achieved 99.2% compliance in this period.

Swab count audit data provided by the trust included measures for swab counts for normal deliveries, for suturing, for instrumental deliveries, and for fetal blood sampling.

At trust level, data provided from March 2017 to March 2018 showed the following levels of compliance for swab count checks across the individual measures: 99.2% for normal deliveries, 98.8% for suturing, 99.4% for instrumental deliveries, and 95.1% for fetal blood sampling.

Over the same period, data specific to this hospital showed the following levels of compliance for swab count checks across the individual measures: 99.6% for normal deliveries, 99.8% for suturing, 100% for instrumental deliveries, and 100% for fetal blood sampling.

The staff informed us they audited all sets of patients records each day. This included the surgical site infection (SSI) bundle, WHO check list-ward, anaesthetic room, theatre and recovery documentation. Where there were omissions in the records the member of staff responsible for the omission, were asked to retrospectively complete, time, date and sign the record.

Risk assessment at antenatal booking took place for all women to determine whether individuals were high or low risk.

There were processes in place in the event of maternal/baby transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
Midwifery and nurse staffing

Planned vs actual

The trust reported their registered nursing and midwifery staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>92.8</td>
<td>92.5</td>
<td>91.6</td>
<td>94.0</td>
</tr>
</tbody>
</table>

In January 2018, the trust had a nursing and midwifery staff fill rate of 98.9% in maternity, with 2.3 fewer WTE staff in post than the trust planned to provide safe and effective care.

For the previous year (January 2017,) the trust had a 1.0% over-establishment of nursing and midwifery staff with both sites reporting more staff in place than were planned.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between March and May 2018, we saw 34.5 (2.7%) occasions which did not meet the planned staff numbers. During this time the service reported seven red flag events. Red flag events are reported by the service when care or treatment such as induction of labour is delayed when there are not enough midwives available to provide safe care. We found none of the red flag events were reported when staffing levels did not meet the planned levels. There was an additional midwife who worked between 09.00am and 17.00pm, the role of this midwife was to support with the triage of patients and the elective caesarean section list. We found this additional shift was not staffed on 14 (15%) occasions.

During our inspection we visited delivery suite. Five staff were planned to work, (four midwives and one health care assistant) and actual staffing levels in the afternoon included an extra midwife.

Vacancy rates

Annual vacancy rates for nursing and midwifery staff in maternity from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>34.1</td>
<td>852.3</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 3.2% for nursing and midwifery staff in maternity, which was below the trust’s target vacancy rate of 6.3%. This hospital met the trust’s target for the vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

The annual turnover rates for nursing and midwifery staff in maternity from February 2017 to January 2018 are shown below.
<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>6.24</td>
<td>10.72</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 7.9% for nursing and midwifery staff in maternity, which was lower than the trust's target of 9.4%. Scunthorpe General Hospital did not meet the trust's target for turnover rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Sickness rates for nursing and midwifery staff in maternity from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>1,904.1</td>
<td>23,363.8</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 6.9% for nursing and midwifery staff in maternity, which was higher than the trust's target of 4.1%. Scunthorpe General Hospital did not meet the trust target for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

A review of maternity services at the site undertaken by representatives from the trust, local clinical commissioning groups (CCG), and health watch was carried out 14 June 2017. Findings stated staff spoken to felt that there was not enough staff and that it was a stressful environment to work in which made them feel like they were not doing a good job.

A non-clinical member of staff felt that the midwives worked hard and that they had a lot of stress. Staff reported working additional hours so that they could keep on top of their work. It was also recognised that there was a pending retirement ‘bulge’ and the impact that this would have on an already stretched staffing resource.

We reviewed maternity staff sickness data submitted by the trust for this hospital. Following high levels of sickness absence in the preceding months (an average of 10.3% from May to September 2017); we found the sickness rate on central delivery suite ranged from 5.6% to 5.9% from December 2017 to January 2018. This had fallen back to within target level (less than 4.1%) in February 2018.

From May 2017 to February 2018, there was an average sickness rate of 9.9% on ward 26 (postnatal ward). This was recorded as 9.3% in January 2018 and 10.9% in February 2018.

We saw very high rates of sickness absence in the maternity antenatal unit from May to November 2017, ranging from 8.6% to 28.8%. However, this had fallen to within the trust target from December 2017 to February 2018.

We reviewed the maternity risk register, dated to February 2018. Staffing at Scunthorpe General Hospital (ward 26 and the central delivery suite) was added to the register in December 2016 as presenting a high risk.
Following the recruitment of staff and use of the trust escalation procedures to move midwives between sites, including calling on community midwives for support, the staffing risk in maternity services at Scunthorpe General Hospital was downgraded to moderate in November 2017.

An update about nursing, midwifery and care staffing capacity and capability was presented to the trust Board 30 January 2018. The update described mitigating actions had been put in place as per trust escalation policy. This included calling in supportive resource from the community midwifery team, and escalating staffing concerns to matrons.

We noted that the ‘Home Birth / Goole Discussion Checklist’ (review date October 2020) contained a checklist to ensure women understood a homebirth might not be possible due to unforeseen circumstances. Circumstances included several homebirths happening at once, severe weather, sudden sickness of midwife, and excessive workload on the maternity at this hospital.

A further update was added to the maternity risk register for staffing at Scunthorpe General Hospital in January 2018 that stated, ‘escalation has improved’, however, it was poor for community and was added to the risk register as a separate risk. The staffing risk remained moderate. A separate entry for community midwifery staffing had not been added to the risk register when it was reviewed (dated February 2018).

Staff sickness data submitted by the trust showed a14.5% sickness rate in the Scunthorpe and Goole community midwifery team in November 2017. In December 2017, the sickness rate was 10.6%. In the months of January 2018 and February 2018, the sickness rate ranged between 1.6% to 3.8% and was within trust target (4.1%).

A further update about nursing, midwifery and care staffing capacity and capability was presented to the Board on 27 March 2018. The update detailed sickness levels in community midwifery needed to be monitored to ensure cover could be provided. The report did not specify which community midwifery team (if one in particular) this referred to.

Data provided by the trust showed from April 2017 to March 2018, showed the average community caseload within the Scunthorpe and Goole community team was 143 women per midwife. The current recommended Birth-rate plus ratio, allowing for some changes in allowances and the NICE guidance since 2009, is 96 cases per WTE midwife.

Bank and agency staff usage

The nursing bank and agency staff usage from February 2017 to January 2018 is shown below:

**The nursing bank and agency staff usage**

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0 (0.0%)</td>
<td>29 (33.7%)</td>
<td>32 (37.2%)</td>
<td>86</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>246 (12.4%)</td>
<td>626 (31.6%)</td>
<td>488 (24.6%)</td>
<td>1,981</td>
</tr>
</tbody>
</table>

There was a total of 901 nursing shifts filled by bank or agency staff in maternity which represented 43.6% of all available shifts, and 25.2% of all shifts remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Midwife to birth ratio
From October 2017 to September 2017 the trust had a ratio of one midwife to every 28.1 births. This was similar to the England average of one midwife to every 26.8 births. This was an improvement on the trust’s performance in the previous period where from September 2015 to August 2016 there was one midwife to every 30.1 births.

(Source: Electronic Staff Records – EST Data Warehouse)

The Birthrate plus classification of the midwife to birth ratio is that only the midwives in the current funded establishment should be counted; bank and agency staffing numbers should not be included in the calculations.

During our inspection we found the midwife to birth ratio across the trust was 1:28 against establishment level as of March 2018 (range 26.5 to 28 from April 2017 to March 2018). This was the same as the national minimum recommendation of 1:28.

However, at this hospital, the midwife to birth ratio was 1:25 (against establishment level) as of March 2018 (range 23 to 30 from April 2017 to March 2018). This was better than the national minimum recommendation of 1:28.

We saw additional midwife to birth ratios at this location which were calculated as including bank and agency staff (1:23 in March 2018) and against establishment level excluding staff on maternity and long-term sickness leave (1:26 in March 2018). Both measures are better than the national recommendation of 1:28.

Data from May 2017 to April 2018 showed 84.5% of women received one-to-one care in labour at the trust. The proportion of women who received one-to-one care varied from 82.3% to 86.0% over the period. Site-specific information was not provided.

A review of maternity services at this site was carried out on the 14 June 2017. The local Clinical Commissioning Group (CCG), Healthwatch and representatives of the trust carried out the review. The findings showed women were concerned regarding induction of labour delays, but clearly understood the reasons for this and that it was to ensure all women were cared for safely.

Medical staffing
Planned vs actual
The trust reported their medical staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>15.9</td>
<td>16.0</td>
<td>16.3</td>
<td>14.7</td>
</tr>
</tbody>
</table>

In January 2018, the trust had a medical staff fill rate of 97.2% in maternity, with 0.8 fewer WTE staff in post than the trust planned to provide safe and effective care. For the previous year (January 2017) the trust had a staff fill rate of 98.3%.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates
Annual vacancy rates for medical staff in maternity from February 2017 to January 2018 are shown below.
<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>11.6</td>
<td>142.1</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 5.6% for medical staff in maternity, which was below the trust’s target vacancy rate of 6.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Annual turnover rates for medical staff in maternity from February 2017 to January 2018 are shown below.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>0.59</td>
<td>8.5</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 4.6% for medical and dental staff in maternity, which was lower than the trust’s target of 9.4%. Diana, Princess of Wales and Scunthorpe General hospitals met the trust’s turnover target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Sickness rates for medical in maternity from January 2017 to December 2017 are shown below.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>9.0</td>
<td>3,087.9</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 0.7% for medical and dental staff in maternity, which was lower than the trust’s target of 4.1%. Scunthorpe General hospitals met the trust sickness target.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

The medical bank and agency staff usage from February 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>77</td>
<td>86</td>
<td>9</td>
</tr>
</tbody>
</table>

The trust did not provide the total medical and dental shifts available, therefore bank and locum
usage cannot be calculated.

In maternity, from February 2017 to January 2018, a total of 222 medical and dental shifts were filled by bank staff and 305 shifts were filled by locum staff. There were 9 shifts that remained unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

In December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 45.1 whole time equivalent staff working in maternity at Northern Lincolnshire and Goole NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>32%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>35%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>13%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

We saw secure storage facilities for paper records at this hospital. Electronic records were also kept, and procedures for safe storage were in line with data protection requirements.

Handheld notes were carried by women throughout pregnancy, in line NICE Quality Standard (QS) statement 3.

In March 2018, as part of their audit programme the trust re-audited multidisciplinary records of women using the service. At the time of viewing, the report was in draft format and had not been presented to the audit meeting or the Obstetrics & Gynaecology Governance Group and an action plan had not yet been produced.

The results of the audit were encouraging with a number of standards achieving over 90% compliance. However, issues were also identified.

We inspected 10 sets of patient records at the inspection and found general record keeping was of a good standard.
We inspected the birth register and found one of the deliveries noted in a serious incident was not recorded. Following the inspection, we made the trust aware of this and they carried out their own birth register audit. The trust did not find the same omissions in the review of the documentation.

**Medicines**

Staff had access to up to date electronic medicine policy guidelines via the trust intranet and the trust pharmacist visited the wards and departments weekly.

The storage and checking of medicines, including the medicines refrigerator temperatures and controlled drugs were taking place in line with policies and procedures.

The storage and checking of medicines, including the emergency trolleys and medicines refrigerator temperatures were taking place.

Controlled drugs were stored correctly and recorded in the appropriate book.

Where appropriate allergies were recorded and the writing was legible.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported one incident which was classified as never event for maternity.

This was recorded as a maternity/obstetric incident meeting serious incident (SI) criteria: mother only and refers to a retained foreign object post procedure which occurred in May 2017 at Diana, Princess of Wales Hospital.

(Source: Strategic Executive Information System (STEIS))

Monitoring of the action plan from the incident was shown in the Obstetrics & Gynaecology Clinical Governance meeting minutes for 26 January 2018. Minutes of the meeting showed the action plans were due to be completed the following month (February 2018).

A further update was provided in the Obstetrics & Gynaecology Clinical Governance Meeting minutes for 23 February 2018. The minutes stated the action plan has not been completed due to some of the actions regarding controlled documents were being reviewed. The reasons for the extension to the action plan was submitted to the commissioners. The Obstetrics & Gynaecology Clinical Governance group agreed to a new date for completion of the document; 31 July 2018.

Staff were aware of the incident, the changes in practice and the learning taken place. This included all staff watching a training video and signing to show they had completed it.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in maternity, which met the reporting criteria set by NHS England from March 2017, to February 2018.
A breakdown of the incident types is shown below:

- Seven maternity/obstetric incident meeting SI criteria: mother only (59% of total incidents).
- Three maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) (25% of total incidents).
- One abuse/alleged abuse of adult patient by staff (8% of total incidents).
- One sub-optimal care of the deteriorating patient meeting SI criteria (8% of total incidents).

Seven of the 12 incidents occurred at Diana, Princess of Wales Hospital, four at Scunthorpe General Hospital and one reported in the community.

(Source: Strategic Executive Information System (STEIS))

The service reported a cluster of eight serious incidents, two of which took place at SGH between October 2017 February 2018. The main theme identified regarded bladder care, all staff we spoke with informed us there had been an increased focus on the completion of fluid balance charts and identification of bladder concerns.

The trust had a policy for reporting incidents, near misses and adverse events in maternity services. Staff we spoke with said they were encouraged to report incidents and were aware of the process to do so.

Staff reported incidents on the trust’s electronic incident-reporting system. We reviewed four root cause analysis (RCA) reports and associated actions plans. We found the structure had improved since our previous inspection in 2016 and clearly identified the root cause of the incident.

The service used internal communication methods to inform staff of learning and changes to practice (for example, the weekly learning memorandum from the interim head of midwifery). We found highlights posted on staff notice boards and minutes of meetings where staff signed to show they were aware of the information.

The Duty of Candour (DoC) is a legal duty for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that had led to moderate or significant harm. Staff we spoke with could discuss the principles of duty of candour and gave examples of when it applied. We found evidence of DoC discussions when reviewing meeting minutes. The staff we spoke with said they were open and honest with women if things went wrong.

Safety thermometer

During our 2016 inspection, we recommended the trust begin to upload data to the maternity safety thermometer. The trust had submitted this data since January 2017.

The NHS safety thermometer was a national improvement tool for local measuring, monitoring and analysis of harm and to assist in working to achieve harm free care.

Measurement of the data is intended to focus attention on patient harms such as pressure ulcers, urinary tract infections in women with a catheter and blood clots. Data collection took place one day each month and the date of collection could change.

The graphs below identify the levels of harm free care for the maternity service.
The graphs showed mixed results for the perception of harm free care for the service. However, between August 2017 and February 2018, women reported feeling safe 100% of the time.

Is the service effective?

Evidence-based care and treatment
The delivery of care and treatment provided to women was based on guidance issued by professional and expert bodies. This included NICE, Royal College of Obstetricians and Gynaecologists (RCOG), Nursing and Midwifery Council (NMC), and evidence-based practice.

Local policies, procedures and clinical guidance were accessible on the trust internet site, which staff found easy to navigate. We checked 16 policies and with the exception of two, which were being reviewed, they were current and reflected quality standards and national guidance.

During the inspection, we saw a centrally held document control register. The register listed all trust policies and clinical guidelines; alongside version controls, review dates, and the different stages of review (where applicable). A named individual at the trust had oversight of the register. The governance midwife informed us that a maternity specific document register was emailed to them each month. From this, they were able to have oversight of documents approaching a review date and take necessary action to ensure they were reviewed and revised.

We looked at the maternity specific document register. We saw appropriate actions were in place for documents that had expired or were approaching their review date. For example, named individual staff were listed against policies currently being reviewed together with a date for submission for approval.

**Nutrition and hydration**

There was a specialist infant feeding coordinator. They led on the implementation and training associated with the United Nations Children’s Fund (UNICEF) Baby Friendly Initiative (BFI) standards.

The UNICEF initiative is a worldwide programme that encourages maternity hospitals to support women to breastfeed.

UNICEF BFI professional officers inspected in October 2017 and re accredited the service with full UNICEF baby friendly accreditation, level 2.

The trust-wide breastfeeding initiation rates for deliveries that took place in hospital from March 2017 to April 2018, showed an average of 68.2%. This was lower than the trust’s target rate of 74.4% and same as the Yorkshire and Humber average of 68.2.

The maternity dashboard figures for Diana Princess of Wales Hospital showed an average, breastfeeding initiation rate of 59.3% from April 2017 to March 2018.

There was a wide range of information and videos available on the maternity trust website about breastfeeding including maximising breast milk and hand expression.

There was a dedicated infant feeding team with a remit to provide support for mothers in hospital and community settings, and in women’s own homes. The service was open to referrals from any health and social care professional, and women could self-refer.

Ward 26 had educational information about breast feeding displayed. There was an infant feeding room that new mums could use to prepare feeds.

Women said they felt well supported. Women said staff had shown them how to make up formulas and felt supported with breastfeeding.

Women had no concerns about the food. Dietary and religious requirements were catered for.

**Pain relief**
Women received detailed information of the pain relief options available to them, this included Entonox piped directly into all delivery rooms, and pharmacological methods such as Diamorphine.

All women said they were able to access pain relief in a timely way, analgesia was offered regularly and their pain was well managed.

Anaesthetic cover was provided on the delivery suit 24 hours a day and included an epidural service. Out of hours cover was shared with the intensive care unit. Staff told us they had not experienced concerns when requesting an anaesthetist out of hours.

The trust monitored delays in providing the epidural service. Evidence provided by the trust showed there had been nine delays across the trust (in a twelve-month period) from April 2017 to April 2018.

A birthing pool was available on the labour ward.

**Patient outcomes**

There was an audit programme across maternity services. Monthly measures included compliance with obstetric early warning scores, intrapartum fresh eyes, swab counts, resuscitation trolley checks, and the WHO five steps to safer surgery checklist. Data was presented at trust level, for this service.

**National Neonatal Audit Programme**

In the 2017 National Neonatal Audit, this hospital's performance in the two measures relevant to maternity services was as follows:

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 68 eligible cases identified for inclusion, 88.1% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit's recommended standard of 85% for this measure.

Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 12 eligible cases identified for inclusion, 25.0% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was lower than the national aggregate of 43.5% and put the hospital in the middle 50% of all units.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Standardised Caesarean section rates and modes of delivery**

From October 2016 to September 2017 the total number of caesarean sections and standardised caesarean section rates for both elective and emergency sections were all similar to expected.
### Standardised caesarean section rates

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesarean s (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.2%</td>
<td>491</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.5%</td>
<td>491</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.7%</td>
<td>982</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Note: Delivery methods are derived from the primary procedure code within a delivery episode.

The trust’s maternity dashboard showed the proportion of women who had an elective caesarean had decreased from 11.8% in quarter two of 2017-2018 to 10.7% in quarter three of 2017-2018. The Yorkshire and Humber average for quarter three of 2017-2018 was 10.4%.

The proportion of women who had an emergency caesarean had decreased from 12.5% in quarter two of 2017-2018 to 10.6% in quarter three of 2017-2018. The Yorkshire and Humber average for quarter three of 2017-2018 was 14.2%.

The overall rate of caesarean sections at the trust for quarter three of 2017-2018 (21.3%) was lower than the Yorkshire and Humber average (24.6%).

Maternity dashboard data for this hospital and Goole and District Hospitals showed from April 2017 to March 2018, the elective caesarean rate was 12.0. This was slightly higher than the trust target of 11%. The emergency caesarean rate was 14.8%; this was lower than the trust target threshold of 15.2%. The overall rate of caesarean sections was 26.8% over the period, falling slightly short of a trust target of 26.2%.

In relation to other modes of delivery from October 2016 to September 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

### Proportions of deliveries by recorded delivery method

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>982</td>
<td>23.4%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>351</td>
<td>8.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>2,850</td>
<td>68.0%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>11</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,194</td>
<td>100%</td>
</tr>
</tbody>
</table>
The trust had a higher rate of non-interventional deliveries than the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The maternity dashboard data for this hospital and Goole District and General Hospital showed from April 2017 to March 2018, the non-assisted delivery rate was 66.0% and the assisted delivery rate was 4.2%

Maternity active outlier alerts

As of January 2018, the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.5. This is based on data collected from January 2015 to December 2015.

This is up to 10% higher than the average for the comparator group rate of 5.2, which indicates their performance was worse than expected.

(Source: MBRRACE UK)

The MBRRACE Perinatal Mortality Surveillance report action plan, completed between July 2017 and November 2017, showed 16 actions. These included, increased screening, better provision of multidisciplinary training in situational awareness and human factors, clearer pathways for women who present with reduced fetal movements, and multidisciplinary management of women with diabetes.

Maternity dashboard data for this hospital and Goole and District Hospitals showed from April 2017 to March 2018:

- The induction of labour rate was 29.8%; this was slightly worse than the trust target of 27.9%;
- The stillbirth rate total (per 1000 births) was 4.13. This was better than the trust target threshold of 4.17;
- The proportion of women who had a normal delivery and experienced a third or fourth degree tear was 1.3%;
- The proportion of women who had an assisted delivery and experienced a third or fourth degree tear was 7.7%;
- There were no trust targets (thresholds) for third or fourth degree tears displayed on the maternity dashboard. However, as a comparator, 6.3% of women had an assisted delivery and experienced a third or fourth degree tear within the Yorkshire and the Humber region in quarter three of 2017 to 2018.
- The service had reviewed the contributory factors for the increased rates of assisted delivery third and fourth degree tears and put processes in place which they said reduced the incidence of the tears.
Maternity dashboard data for this service and Goole and District Hospital showed, from December 2017 to March 2018, the average proportion of women who had an assisted delivery and experienced a third or fourth degree tear was 2.3%.

From April 2017 to March 2018, 1.7% of women experienced a postpartum haemorrhage of greater than 1500mls;

There were no trust targets (thresholds) for postpartum haemorrhage displayed on the maternity dashboard. However, as a comparator, 2.8% of women had experienced a postpartum haemorrhage of greater than 1500mls within the Yorkshire and the Humber region in quarter three of 2017 to 2018.

Data showed from August 2018 to April 2018, two women were transferred from Scunthorpe General Hospital to this hospital. Both transfers occurred for clinical reasons.

**Competent staff**

**Appraisal rates**

From April 2017 to January 2018, 84% of staff within maternity at the trust had received an appraisal compared to a trust target of 95%.

**Appraisal rates:**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff who have received an appraisal</th>
<th>Total staff required to complete appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>1</td>
<td>1</td>
<td>95%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>9</td>
<td>10</td>
<td>95%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>24</td>
<td>27</td>
<td>95%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>66</td>
<td>81</td>
<td>95%</td>
<td>81.5%</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>119</td>
<td>95%</td>
<td>84.0%</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital had an 84.0% appraisal completion rate overall for maternity.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Community midwifery staff**

Data we received from the trust showed from April 2017 to January 2018, 73% of qualified community midwifery staff at the trust had received an appraisal compared to a trust target of 95%.

<table>
<thead>
<tr>
<th>Name of location / team</th>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe and Goole community midwives</td>
<td>Qualified Nursing Midwifery Staff</td>
<td>20</td>
<td>16</td>
<td>95%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Data showed 16 of 20 qualified midwifery staff (80%) at Scunthorpe General Hospital and Goole District Hospital had received an appraisal in this timeframe.
The trust provided performance appraisal and development review (PADR) data for maternity services, received May 2018. Data for this hospital showed the proportion of staff from different teams/wards who had received a PADR in the previous 12 months as follows:

- Maternity Antenatal Unit (91%)
- Maternity Central Delivery Suite (96%)
- Maternity Ward 26 (postnatal ward) (72%)
- Maternity Ward Pregnancy Assessment Unit (100%)
- Midwifery Breast Feeding Support (100%)
- Medical Staff Maternity (0%)

Following our inspection in June 2017, the trust had recruited a clinical skills and patient safety midwife. The purpose of this role was to be clinically based, highly visible, coordinate the delivery of training and ensure development of the maternity workforce. However, the ward managers managed the allocation of mandatory training. There did not appear to be central oversite of the mandatory training rates.

The trust had an in date clinical supervision policy for registered nurses and midwives. Staff we spoke with told us supervision took place at least annually and was provided by professional midwives advocates; following the advocating for education and quality improvement (A-EQUIP) midwifery supervision model.

Medical staff undertook annual competency checks for their registration.

Support was provided to staff during their preceptorship period (newly qualified midwives) this included “camp care” which was a week where new staff received all IT access, induction training identification badges. New staff were also supported in theatre by the clinical skills and patient safety midwife to ensure safety was maintained.

There was also a preceptorship programme to support progression for band five to band six midwives, over a one to two-year period. Mentorship was also part of the band five to six uplift.

Community midwives were trained in postnatal ‘check up’s’ and new-born and infant physical examination (NIPE). A senior community midwife we spoke with said that a good proportion of community midwives in the locality were new-born infant physical examination (NIPE) trained but was unable to provide us with an exact figure. We saw that an action in the ‘Maternity services patient safety strategy 2018- 2020’ (version 4) detailed a plan to NIPE train all community midwifery staff. This would allow women to be discharged from hospital earlier, with the proviso that new-borns would receive a NIPE check in the community within 72 hours. The strategy stated than the timeframe for implementation was June 2018.

During the inspection, senior community staff told us that all community midwives had received additional ‘baby lifeline’ training focussed on childbirth emergencies in the community. An external provider facilitated the training. There were two cohorts of community midwives, and training had taken place in December 2017 and March 2018. The training was multidisciplinary and completed alongside ambulance crews.

**Multidisciplinary working**

There was a formalised structure of meetings in place to enable multidisciplinary team working. These included monthly maternity governance meetings and perinatal mortality and morbidity meetings.
Midwifery staff at the hospital and in the community reported good communication, information sharing between departments and cross-site working within teams.

Annual emergency skills and drills training and ALERT (Acute Life-threatening Events Recognition and Treatment) training took place alongside medical (obstetric) staff. Community midwives had attended ‘baby lifeline’ training focussed on childbirth emergencies in the community, which involved training alongside ambulance crews.

**Seven-day services**

There was a consultant presence on the central delivery suite from 9:00am until 7:00pm on weekdays; 9am until 2pm at the weekend (60hours). There was designated consultant on-call cover outside of these hours and included weekends.

Access to a dedicated obstetric theatre team was available Monday to Friday from 9:00am until 9:00pm. Outside of these times the service utilised main theatres.

Anaesthetic cover was provided on the delivery suite 24 hours a day and included an epidural service. However, out of hours cover was shared with the intensive care unit.

Staff reported they had not experienced any delay in the provision of the epidural service.

The antenatal day unit was open from 9:00am to 5pm Monday to Friday, if staffing allowed the unit would remain open until 8pm. On a Saturday the unit was open from 8:00am to 4pm and was closed on a Sunday. Out of hours women were seen on ward 26.

An on-call pharmacy service was available.

There was access to diagnostics and imaging services out of hours.

On-call community midwives were available twenty-four hours a day, seven days a week.

A serious incident had occurred in the community in the 12 months prior to our inspection. Learning from the incident (report completed April 2018,) included a request by the interim Head of Midwifery to implement a more robust on-call system for community midwives, including a second on-call system, for all home births. Discussion with one of the community managers identified a second on call member of staff is used.

**Health promotion**

There were midwives across the trust, available for support and guidance and with special interests as part of their role. These included midwives who specialised in smoking cessation, substance abuse, bereavement and infant feeding.

The maternity dashboard data showed the proportion of women smoking at time of booking across the trust was 20.8% in quarter three of 2017-2018. This was lower than the trust’s target rate of 11% and higher than the Yorkshire and Humber average for the period (18.4%).

The proportion of women smoking at time of delivery across the trust was 21.2% in quarter three of 2017-2018. This was lower than the trust’s target rate of 11% and higher than the Yorkshire and Humber average for the period (13.4%).
Maternity dashboard figures for Diana Princess of Wales Hospital showed that from April 2017 to March 2018, the proportion of women smoking at time of booking was 21.9% and the proportion of women smoking at time of delivery was 19.9%.

Senior community midwifery staff told us smoking cessation clinics were available in the locality. However, smoking rates were high, as the areas covered were socio-economically deprived. As part of their MBRRACE Perinatal Mortality Surveillance Report action plan, the trust was investigating service provision for smoking cessation services, with a view to expanding provision. The report was submitted to Directorate Governance Group in April 2018.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust did not provide mental capacity act and deprivation of liberty safeguards training data.

*(Source: Trust Provider Information Request P14/P49)*

There was a trust-wide Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policy, due for renewal in April 2018. There was a MCA/DoLS lead at the trust, who told CQC staff that a new policy had been written and awaited ratification at the next governance meeting.

There was also a trust level named nurse for the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The area of risk was identified in 2017, and the post established.

The Safeguarding Lead for the trust told us the MCA and DoLS training focused on the consent to treatment.

As of end of April 2018, compliance with MCA training was 74%, DoLS Level 1 training, 77% and Level two training, 56%. The trust was reviewing which staff require Level two, DoLS training.

During our visit, a senior member of staff told us that MCA and DoLS training sessions were planned for community midwives. However, staff were waiting a date for this training to take place.

Staff we spoke with at the midwifery-led unit and in the community staff clearly articulated the use of Gillick competency for consent of patients under the age of 16 years.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

**Friends and family test performance (antenatal), Northern Lincolnshire and Goole NHS Foundation Trust**
From January 2017 to January 2018 the trust’s maternity friends and family test (antenatal) performance (% recommended) was in line with the England average for all months in the period aside from June and July 2017 where performance fell below the England average. The trust reported 100% recommend for three months during the period (March, May and August 2017).

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns and the trust had less than six responses in December 2017 and January 2018 which shows on the graph as 0% recommend.

Friends and family test performance (birth), Northern Lincolnshire and Goole NHS Foundation Trust

From January 2017 to January 2018, the trust’s maternity friends and family test (birth) performance (% recommended) was better than or in line with the England average, reporting 100% recommend for six months during the period (February, March, April, May, June and December 2017).

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

Friends and family test performance (postnatal ward), Northern Lincolnshire and Goole NHS Foundation Trust

From January 2017 to January 2018, the trust’s maternity friends and family test (postnatal ward) performance (% recommended) was better than or in line with the England average, reporting
100% recommend for seven months during the period (February, June, July, August, September, October 2017 and January 2018).

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

**Friends and family test performance (postnatal community), Northern Lincolnshire and Goole NHS Foundation Trust**

From January 2017 to January 2018, the trust’s maternity friends and family test (postnatal community) performance (% recommended) was generally worse than the England average. The trust reported less than six responses in four of the months in the period (February, March, April 2017 and January 2018) which show on the graph as 0% recommend.

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

*(Source: NHS England Friends and Family Test)*

**CQC Survey of women’s experiences of maternity services 2017**

In the CQC maternity survey 2017, the trust performed about the same as other trusts.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>7.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
</tbody>
</table>
If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time? 9.3 About the same

Thinking about your care during labour and birth, were you involved enough in decisions about your care? 8.9 About the same

Thinking about your care during labour and birth, were you treated with respect and dignity? 9.0 About the same

Did you have confidence and trust in the staff caring for you during your labour and birth? 8.7 About the same

Care in hospital after the birth

Looking back, do you feel that the length of your stay in hospital after the birth was appropriate? 6.9 About the same

Looking back, was there a delay in being discharged from hospital? 5.3 About the same

Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time? 7.6 About the same

Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? 8.0 About the same

Thinking about your stay in hospital, how clean was the hospital room or ward you were in? 9.0 About the same

Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? 8.2 About the same

Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted? 8.4 About the same

We observed patients treated with privacy and dignity. When patients had treatment or care, we observed curtains were drawn round their bed and doors closed. Staff knocked on doors and sought permission before entering rooms. Patients told us, the staff respected their privacy and dignity; they were kind and caring.

We observed the service had received thank you cards from patients and relatives. Thanking staff for the support and treatment received during their stay.

**Emotional support**

There were guidelines and care pathways to support mothers and their family in the event of a miscarriage, termination for fetal abnormality, stillbirth, or neonatal death.

There was a consultant-led 'rainbow clinic'. The 'rainbow clinic' was a specialist service for women and their families in a subsequent pregnancy following loss; and women were able to self-refer. A specialist bereavement midwife was in post, who worked across sites.

There was an information booklet outlining options for funeral arrangements, which offered the services of the hospital chaplaincy and the support of local funeral directors, if needed. The booklet contained information about an annual baby memorial service, which took place in Scunthorpe, and a baby memorial book; held in the hospital chapel.

We saw that the trust was working with Sands (the stillbirth and neonatal death charity) to implement and test a new National Bereavement Care Pathway (NBCP) for pregnancy and baby loss. The trust implemented the pathway in April 2018 and will be working with Sands to understand the impact of the pathway and its effectiveness in improving bereavement care for
parents. Five experiences of pregnancy or baby loss were part of the pathway. Including, miscarriage, termination of pregnancy for foetal anomaly, stillbirth, neonatal death and the sudden unexpected death of an infant up to 12 months.

Staff had previously helped to raise over £100,000 for a bereavement suite as part of the service.

‘Butterfly stickers’ were used in antenatal notes to indicate women had previously experienced pregnancy loss and baby bereavement. Butterfly door signs were used in the hospital to indicate a current loss.

The trust had also introduced ‘cherished care packs,’ to be given to parents following a still birth or neonatal death. There was a range of keep sake materials available for women to choose from, to suit different types of loss and different baby gestations.

Information leaflets available about baby loss and bereavement were available, including those from the Mariposa Trust, ‘4Louis’, and the ‘Blue Butterfly Support Group.’ These included contact details for national charities and local support groups.

**Understanding and involvement of patients and those close to them**

In the 2017, CQC maternity survey, for being involved enough in decisions about their care during labour and birth, women scored 8.9 out of 10, across the trust (which was about the same as other trusts, and an improvement on their 2015 score of 8.4).

An external provider undertook a survey of women who had recently used maternity services at the trust in September 2017. An action plan was developed to address women’s concerns and recommendations. For each action, there was an action lead, timescale for completion (all set for August 2018) and expected evidence of completion (anticipated changes to practice and delivery).

In the antenatal period, the service planned to implement greater choice of where to have check-ups, greater awareness of women’s medical history, better continuity of care, and greater focus on emotional and mental well-being. The plan recognised that during birth, women needed to be able to move more freely, have concerns taken seriously, and be treated with dignity and respect. Improvements in postnatal care included considering women’s preferences about the length of hospital stay (if applicable), attending to women more quickly, listening to and respecting women’s decisions, providing or signposting to enhanced emotional care, and providing more information about postnatal check-ups.

There was an established Maternity Voices partnership in place. The partnership had a remit to enable hospital trust and other service providers, to listen to and take account of the views and experiences of maternity service users. Parents who had delivered a child at the trust in the last three years were invited to join and share their experiences of care. The group was comprised of local parents, commissioners, hospital, community and council staff, and chaired by a local mother. The group met every two months in Scunthorpe or Grimsby, and there was a social media page and online forum. Experiences of care could also be submitted by email.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Women had the option to either deliver at home, in the midwifery led unit at Goole and District Hospital, this hospital, or Diana Prince of Wales Hospital. Community midwives carried out routine antenatal care. Hospital antenatal clinics were available for higher risk women. Midwives could refer expectant mums to the hospital antenatal clinic if they developed any problems.
Maternity services worked with the local commissioners of services, the local authority, other providers, GP’s and patients to coordinate care pathways.

Clinics were held within the antenatal clinic to support women, such as smoking cessation clinics and diabetic clinics.

Partners were encouraged to stay overnight from delivery to support their partners.

Ward 26 had an area dedicated for transitional care. This was an area where babies who needed a little more support could stay with their mum rather than go to the Special Care Baby Unit. This meant mum and baby did not have to be separated.

There was a consultant-led ‘rainbow clinic’. The ‘rainbow clinic’ was a specialist service for women and their families in a subsequent pregnancy following loss.

**Bed Occupancy**

From Q2 2016/17 to Q3 2017/18, the bed occupancy levels for maternity were lower than the England average in all periods. The trust had 44.1% occupancy in Q3 2017/18, compared to the England average of 58.9%.

The chart below shows the occupancy levels compared to the England average.

(Source: NHS England)

Data provided by the trust showed from April 2017 to March 2018, 48% of maternity beds were occupied at midnight (mothers only) across the trust.

Over the same period, 49% of maternity beds were occupied at midnight (mothers only) at Scunthorpe General Hospital. Of these, 35% of beds were occupied at midnight on the central delivery suite, and 53% of beds were occupied at midnight on ward 26.
From April 2017 to March 2018, data showed 53% of maternity beds were occupied at midday (mothers only) at Scunthorpe General Hospital. Of these, 37% of beds were occupied at midday on the central delivery suite, and 69% of beds were occupied at midday on ward 26.

**Meeting people’s individual needs**

Women could book their initial antenatal appointment directly, by telephone or online and did not require referral.

Women were offered the choice to deliver at home, in a midwifery-led birthing suite, or in hospital.

The service offered educational childbirth preparation classes run by midwives. Topics included, signs of labour and when to come into hospital, natural coping strategies, stages of labour including pain relief options, assisting your partner in labour, variations of normal delivery including caesarean section, and an introduction to baby feeding.

Midwives were available for support and guidance with special interests as part of their role. These included midwives who specialised in safeguarding, teenage pregnancy, smoking cessation, substance abuse, bereavement, and infant feeding.

A face-to-face and telephone translation service was available, provided by ‘Big Word Translation’ services and British Sign Language signers.

The trust had also applied ‘Browse Aloud’ to their external web pages, to enable audio capabilities for those with visual impairments. ‘Browse Aloud’ allowed users to listen to an audio reading of web content in different languages.

There was a chapel and a prayer room at this hospital with multi-faith provision. The chaplaincy team at the trust provided an out of hours on-call service for part of the week.

There was a policy and procedure for ‘Spiritual Care Standards’ (DCP280) in place at the trust, which outlined the importance of respecting the religion and belief of all, regardless of creed.

**Access and flow**

The trust reported no maternity unit closures for the 12 months prior to inspection.

From April 2017 to March 2018, the bed occupancy levels for maternity were lower than the England average.

The maternity dashboard data showed from February 2017 to January 2018, (inclusive) 89.5% of initial antenatal bookings across the trust were undertaken before 13 weeks. This was marginally below the trust target of 90% and below the Yorkshire and Humber average for the period (91.7%).

For the same period, bookings within the 13-week threshold minus agreed exclusion targets (such as mothers presenting later in pregnancy) was 97.4%.

There were processes in place to follow up women who did not attend appointments, either in the community or hospital setting. This was to ensure the well-being of the mother and their child.

The central delivery suite was responsible for triaging any women who contacted the service. A standard operating procedure for telephone triage was in use and a call screening maternity assessment record was completed.
The antenatal day unit (ADU) was open 8am to 9pm Monday to Friday and 8am to 4pm, Saturday and Sunday and staffed by midwifery staff. The manager told us a meeting was arranged with the IHOM to discuss the relocation of the triage service to ward 26 (antenatal/postnatal ward). One staff member said that on occasions they had experience delays when requiring a consultant presence. The staff were not able to tell us how often this occurred and had not completed an incident form. Women we spoke with visiting this department told us they were happy with their care to date. Staff were welcoming and reassuring. They had not experienced delays in their clinic appointment and their maximum wait had been 10 minutes.

**Learning from complaints and concerns**

**Summary of complaints**

There was a trust complaints policy and staff were aware of the procedure to follow. We saw patient advice and liaison service (PALS) information leaflets on display in the areas we visited. We also saw trust information leaflets on display in the waiting area about how to make a comment, compliment or complaint.

From February 2017 to February 2018, there were 10 complaints about maternity services at this hospital.

Of these, four were currently under investigation, one had been withdrawn, three were not upheld, one was partially upheld (care of mother and daughter and communication) and one was fully upheld (concerns about aftercare post birth).

The trust took an average of 73 working days to investigate and close complaints at the hospital. This is not in line with the trust targets for closing complaints within 30 working days, or the further target of 45 working days.

A breakdown of the subject of complaints is shown below:

- Patient care – six complaints
- Values and behaviours (staff) – two complaints
- Commissioning – one complaint
- Communication – one complaint

*(Source: Trust Provider Information Request P55)*

Across the trust, learning from incidents was discussed at divisional governance and patient safety meetings, and information cascaded to staff at team meetings, safety huddles, and at handovers.

We reviewed monthly obstetrics & gynaecology clinical governance meeting minutes for January, February and March 2018. The information showed detailed PALS and complaints received by hospital site, and the number of open complaints. Data was inclusive of obstetrics and gynaecological services. Trends in complaints were identified. For example, March 2018 meeting minutes highlighted a trend in relation to delay or failure in treatment or procedure.

We saw evidence of learning from incidents. The completed serious incident reports we reviewed captured lessons learned.

The service used internal communication methods to inform staff of learning and changes to practice. We also found highlights posted on staff notice boards.

We also evidence of learning from complaints and concerns. For example, in the maternity
During our visit, we saw a ‘lesson of the week’ circular (dated 04 May 2018) that detailed a thematic summary of the ‘top five PALS/complaints’ across maternity services at the trust. These included communication, clinical treatment/care, staff values and behaviours, misfiling, and appointments including delays and cancellations.

**Is the service well-led?**

**Leadership**

Maternity and gynaecology services formed part of the women’s and children’s group. At the time of the inspection an associated chief operating officer (ACOO), a group clinical lead (GCL) for obstetrics and gynaecology and an interim head of midwifery (IHOM) led the service. Each hospital site had an operational matron. There was a lead consultant for labour ward.

A non-executive director represented the service at board level. Since our previous inspection in 2016 staff reported the service had received a greater focus and scrutiny from the trust board.

The interim head of midwifery had been in post for eight months prior to our inspection. All staff spoke positively of the changes and progress the service had made during this period. The group clinical director had recently come into post prior to our inspection. Staff reported they were confident in this person to lead the clinical team.

There was a coordinator in charge of each shift; this person had oversight of the whole unit. We found they were accessible to all staff and offered support and guidance when required.

We saw the contact details of the whole consultant body on display in clinical areas. Staff reported they were encouraged to call consultants if they were concerned.

The service was receiving support from NHSI in the form of an external partnership with a consultant. The aim was to support the leadership team to drive improvement. At the time of inspection support had been provided of six days and was in the early stages.

**Vision and strategy**

The service had a three to five-year strategy which included strategic objectives and action plan to implement the strategy.

The strategy supported the implementation of better births review of maternity services. It also reviewed clinical and financial pressures and was available in the public domain.

The ‘Women and Children’s Division Strategic Objectives 2017-20’ set out maternity services mission “to provide safe, effective and leading-edge care to the population we cover through nurturing high performing teams that prioritise patient care.”

The vision was for “…every woman and child in our locality is healthy and happy.” Five main strategic goals were stated. These included, encouraging the use of innovative ideas, evidence-based techniques and treatments; by developing midwife/specialist nurse led care, and improving diagnosis and management of ‘small for gestational age’ fetus. In addition, to have the right levels of staff, appropriately trained and delivering excellent care in a positive, compassionate environment. This meant ensuring ‘Birth-rate plus’ establishment for midwifery and safe staff-to-patient ratios were maintained and ensuring appropriate staffing levels.

**Culture**
We observed good team working, with midwives working collaboratively and with respect for each other’s roles. All staff spoke positively and were proud of the progress the service had made since our 2016 inspection.

Evidence provided by the trust showed they had undertaken a staff survey, published in August 2017, to identify the morale of staff. Themes included a lack of positive feedback, and staff reported being valued by patients and their immediate manager but not by the trust as a whole. A follow up survey undertaken in January 2018, showed an improved picture, where staff felt listened to and valued by the Interim Head of Midwifery (IHOM).

Staff told us they were encouraged to be open and honest. This had improved since the new clinical lead had come into post.

Staff told us they felt the senior leadership team did not all have a clinical focus and this had caused a disconnect between some of the leaders and the clinical team. Staff reported some leaders had an autocratic leadership style which did not focus on patients but the bottom line.

We observed an established consultant body who worked collaboratively with the midwifery team.

However, the consultant body, were not aware of their job plan going forward long term and we were told they were not included in RCA investigations. We were told of instances where morale within the medical team was low due to the previous clinical lead not communicating to the team. At the time of our inspection we were told there was a lack of communication from the ACOO.

**Governance**

There was a governance midwife and they attended monthly Obstetrics and Gynaecology Clinical Governance Meetings.

The Obstetrics and Gynaecology Clinical Governance group was responsible for monitoring the performance within the Women & Children’s Group against or in response to performance and other national requirements. For example, the National Service Frameworks, NICE recommendations, and Confidential Enquiry Reports. They had a remit to review and approve applicable policy documents, and to ensure appropriate infrastructures and reporting arrangements were in place. They also had a responsibility to review the serious incidents, incidents, complaints, PALS, case reviews, network reviews and neonatal peer reviews within relevant departments and wards; develop action plans in response to these and share lessons learned. In addition, to review and update any relevant risks on the risk register and monitor any action plans that arise from this. Documents reviewed and staff and patients spoken with showed the governance arrangement were taking place.

**Management of risk, issues and performance**

The women and children’s group risk management strategy, (version 5.3, expiry date February 2019) had been written as an 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 strategy had been approved by the Children’s Services Governance, Obstetrics & Gynaecology Governance, and the trust Governance & Assurance Committees in September 2015 and April 2016.

Key policy areas included the identification, assessment, control and review of risk, the risk register, process for escalation and assurance, reporting and management of incidents, serious incidents, never events, maternal deaths, and learning of lessons.
At the time of viewing (February 2018), the maternity services risk register had 13 entries for obstetric / maternity services (12 entries) and community midwifery (one entry). Six risks were categorised as currently presenting a high risk, five as presenting a moderate risk, and two as presenting a low risk.

We reviewed monthly Obstetrics & Gynaecology Clinical Governance Meeting minutes for January, February and March 2018. We saw evidence that all current maternity risk register entries were reviewed and updates discussed. We also saw that minutes contained action logs pertinent to risks identified in the risk register. For example, a business case for more sonographers and midwives to be trained in scanning.

We also found an overview of serious incidents, incidents and complaints presented in monthly Obstetrics and Gynaecology Clinical Governance meeting minutes for January, February and March 2018. Items included a summary of serious incidents that had occurred in the preceding month, their severity, and thematic summary of the most commonly occurring incidents. Incident data was inclusive of Obstetrics and Gynaecology services. Meeting minutes from both January and March 2018, detailed the root cause analyses, action plans, and timescales from the completed investigations.

The maternity dashboard was location specific and discussed at the monthly governance meetings. The service submitted data to the Yorkshire and Humber regional maternity dashboard. This meant the service could compare its performance against other local trusts and the Yorkshire and Humber average.

**Information management**

Staff had access to clinical guidelines and care pathways on the trust intranet.

There was a centrally held document control register. The register listed all trust policies and clinical guidelines; alongside version control, review date, and stages of review (where applicable) information. A named individual at the trust had oversight of the register. The governance midwife informed us that a maternity specific document register was emailed to her each month for oversight. Appropriate actions were in place for maternity specific documents that had expired or were approaching their review date.

The minutes of the Obstetrics and Gynaecology Governance Group showed monitoring of controlled documents within the services. This included clinical documents, guidelines and patient leaflets.

There was a 'Maternity Project Plan' in place. At the time of viewing this was dated to 18 May 2018. A key milestone was electronic recording of the Obstetrics Early Warning Score (OEWS) for all women expect those receiving high dependency care. This was marked as fully completed in August 2017.

**Engagement**

There was a Maternity Voices Partnership in place at the trust. The partnership had a remit to enable hospital trust and other service providers to listen to and take account of the views and experiences of maternity service users. Parents who had delivered a child at the trust in the last three years were invited to join and share their experiences of care. The group was comprised of local parents, commissioners, hospital, community and council staff, and chaired by a local mother. The group met every two months in Scunthorpe General Hospital, or Diana Price of Wales Hospital, and there was a social media page and online forum. Experiences of care could also be submitted by email.
An external provider carried out a survey of women who used maternity services at the trust in September 2017. An action plan had been developed to address women’s concerns and recommendations. For each action, there was an action lead, timescale for completion (all set for August 2018) and expected evidence of completion (anticipated changes to practice and delivery).

We noted low Friends and Family Test (FFT) responses across maternity services at the trust. No data for the maternity friends and family test was published by NHS England in November 2017; due to data quality concerns. The trust had less than six responses in December 2017 and January 2018 for antenatal care; this resulted in 0% recommended. The trust also reported less than six responses in four months (February, March, April 2017 and January 2018) for postnatal community performance; this too resulted in 0% recommended.

**Learning, continuous improvement and innovation**

A review of maternity services at the site was undertaken by representatives from the trust, local Clinical Commissioning Groups (CCG’s), and Healthwatch on 14 June 2017.

The trust invited the Royal College of Gynaecologists (RCOG) to review and assess maternity services; this took place shortly after our visit in May 2018. Terms of reference showed 10 keys points for consideration, and included a review and assessment of the following areas:

- Current model for the delivery, including the progress and pace of the maternity services improvement plan.
- Provision of care in relation to national standards and indicators.
- Prevalence and effectiveness of a patient safety culture.
- Serious incident investigation processes, and evidence and implementation of learning.
- Current midwife and obstetric workforce and staffing.
- Culture within maternity services, including inter-professional relationships and staff engagement.
- Structure and schedule of meetings and training activities in place.
- Areas of leadership and governance that would benefit from further targeted development.
- Level of patient engagement and involvement within the maternity services.

In early 2018, women who gave birth at Scunthorpe General Hospital, Diana Price of Wales Hospital, or Goole District Hospital were asked to give a special thank you to their midwife by nominating them for an award. Staff in maternity services hosted a tea party in celebration of midwives. The midwives shared their experiences and the reason they loved working in the profession. This took place in May 2018. On the day, the winners of the ‘NLaG Outstanding Midwife 2018 award’ were also announced.

In April 2018, the trust implemented a new National Bereavement Care Pathway (NBCP) for pregnancy and baby loss. This was developed in conjunction with the Sands (the stillbirth and neonatal death) charity.

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.
Data received from the trust showed that from April 2017 to March 2018, the home delivery rate for Diana Princess of Wales Hospital was 1.6% of total births across the locality. This was below the trust’s target of 2.2%.

For the same reporting period, the home delivery rate for Scunthorpe and Goole Hospitals was 2.2% of total births across the locality. This was within the trust’s target threshold (of 2.2% and higher).

### Critical care

#### Facts and data about this service

The trust has 43 critical care beds. A breakdown of these beds by type is shown below.

**Breakdown of critical care beds by type, Northern Lincolnshire and Goole NHS Foundation Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, 51.2%</td>
<td>Paediatric, 7.9%</td>
</tr>
<tr>
<td>Adult, 48.8%</td>
<td>Neonatal, 23.8%</td>
</tr>
<tr>
<td></td>
<td>Adult, 68.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England- Critical Care beds 01/12/2017 – 31/12/2017)
The trust has a critical care service without walls; the service includes outreach services, a sepsis nurse, vascular access and a deteriorating nurse consultant.

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

The unit has a bay containing six beds and two single rooms. The beds flexed between level two and level three as required. The unit could care for a maximum of seven level three patients, or six level three patients and two level two patients.

A critical care outreach team provides a supportive role to the wards caring for deteriorating patients and support to patients discharged from critical care during the day. The hospital at night team provides cover at night. A recent change in hours to both team meant each worked 12-hour shifts enabling a twenty-four seven service.

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

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

Is the service safe?

Mandatory Training

Mandatory training completion rates

Scunthorpe General Hospital

The trust set a target of 85% for completion of mandatory training, at the previous inspection it had been 95%.

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>46</td>
<td>46</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>44</td>
<td>46</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>44</td>
<td>46</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>43</td>
<td>46</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>42</td>
<td>46</td>
<td>91%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing staff at Scunthorpe General Hospital had an overall training completion rate of 90%, meeting and exceeding the trust target of 85%. The trust target was reached and exceeded for eight of the ten training modules. The module, Infection Control – 1 Year, had the lowest training completion rate of 80%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We reviewed information related to mandatory training compliance on site from the quality dashboard. This was available by department and a report sent each month to ward managers. This showed that in May 2018 mandatory training compliance had improved further and overall compliance was 92%.

Training on sepsis was provided for all staff via an e-learning module.

We requested mandatory training data for medical staff within critical care and compliance was 83%.

**Safeguarding**

**Safeguarding training completion rates**

**Scunthorpe General Hospital**

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>44</td>
<td>46</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>44</td>
<td>46</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>42</td>
<td>46</td>
<td>91%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff at Scunthorpe General Hospital met and exceeded the trust target for all three safeguarding training modules, with an overall completion rate of 94%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We requested training data for medical staff and compliance rates were 87% for adults safeguarding training and 90% for level one and two children’s safeguarding.

Trust protocols and guidance on safeguarding were easily accessible and there was a safeguarding team who could be contacted if further advice was needed.
Staff we spoke with could describe what may be seen as a safeguarding concern and how they would escalate this. Senior nurses were confident about staffs understanding of safeguarding.

**Cleanliness, infection control and hygiene**

Eighty percent of nursing staff had completed infection control training against a trust target of 85%.

Intensive Care National Audit and Research Centre (ICNARC) data showed there had been six unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2017 (see funnel plot below). The year to date percentage of unit acquired infections in blood per 1000 patient bed days was 3.9 which was in line with national averages (1.4 – 8.4). However, the second graph shows when compared to similar units; rates have remained higher. This was found to be the case at the previous inspection. We discussed this with the senior management team who said each case had been investigated and no themes had been found.

For the same time period there had been no unit acquired cases of methicillin resistant staphylococcus aureus (MRSA) or *clostridium difficile*.

(Source: Quarterly Quality Report: 1 April 2017 to 31 December 2017 Scunthorpe General Hospital, Intensive Care Unit)

Hand hygiene points were at the entrance to the unit and alcohol gel was available at every bed space. Infection control information was displayed to staff and visitors on the unit. Monthly frontline ownership audits were completed. We were provided with the divisional dashboard, this showed compliance against 10 standards including waste disposal and sharps safety. Data from April 2017...
to April 2018 showed an improving picture with the majority of areas rated as green indicating compliance was above 95%.

High impact interventions were in place for ventilator associated pneumonia (VAP). These looked at best practice and compliance with evidence-based practice for specific procedures. Data from February 2018 showed good compliance with the different areas and that there had been no cases of VAP.

All areas and equipment on the unit were visibly clean and tidy. Labels were applied to equipment to indicate they had been cleaned and were ready for use. The unit had facilities for respiratory isolation and there were systems in place for waste segregation and disposal.

We observed staff interactions with patients, including those requiring isolation, and all were compliant with key trust infection control policies. Without exception, hand hygiene and the use of personal protective equipment (PPE) was undertaken by all staff we observed. Infection control and prevention information leaflets were available for relatives in the visitor’s room.

Environment and equipment

The unit had been refurbished in 2015 and additional storage areas had been created. This had however impacted other areas, for example there were no longer separate male and female changing rooms for staff.

Access to the unit was via intercom with a security camera and there was central monitoring in place. The unit had windows allowing natural light in, however the space limitations in the bay meant it was not fully compliant with health building notice (HBN) 04-02. There was direct access to theatres via a corridor from the unit.

Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance. To maintain patients’ privacy the bed spaces were separated by curtains.

There was adequate equipment in the unit to meet the needs of patients. The replacement of equipment was done as part of the trust wide capital replacement programme. Specialist equipment was available for patients with a high body mass index (BMI) when required.

We checked 33 pieces of equipment for evidence of in date electrical testing. We found these to be in place and in date on all the equipment checked, except for three infusion pumps. We asked about this and the medical physics team promptly attended the unit. It was identified that the pumps had been incorrectly labelled.

There were two blood gas analyser machines which were calibrated at separate times to ensure one was always available. Staff reported there was remote access from technicians if any problems occurred, however no staff could recall any recent problems.

There was a trolley centrally located with a defibrillator and sealed packs of emergency drugs. We saw evidence of daily checks being completed. Other emergency equipment such as airways and syringes were located in the trolleys at each bed space. Each trolley contained the same emergency equipment and had a laminated contents list. Checks were completed at the start of each shift; however, this was not formally recorded. We found all items present and in date in the three trollies we checked.

The unit had a difficult airways and paediatric trolley. These had a contents list and with the exception of a nasal airway that was past its expiry date, the contents were present and in date. It was the responsibility of the co-ordinator to check these each day. We noted that the difficult air way trolley was stored in a side room, however we were told this was the only space available and it did not cause a delay in getting the trolley when it was needed.
The unit had a transfer bag which contained emergency equipment for when external transfers took place. Guidelines for the Provision of Intensive Care Services 2015 (GPICS) state ‘this should contain appropriate equipment for interventions that might be required in transit. The transfer bag should be checked routinely and in between uses to avoid delays when it is needed’. We found there was no system in place to do this. There was no contents list or checklist in place. Nursing staff told us the bag was checked by the anaesthetists. We observed a patient transfer during which a conversation took place between two staff members to clarify what should be in the transfer bag. We could therefore not be assured that the transfer bag was immediately ready for use and that all staff were aware of what it should contain. This was raised with the unit manager at the time of inspection.

During our inspection we asked staff about a fire escape located in a corner of the unit where the bay containing six beds was located. The door was not wide enough to accommodate a bed and the corridor beyond was obstructed by trollies. We were told checks were done to ensure the corridor was clear however this was not the case on the day we observed this. We were concerned that to evacuate via this exit would pose a significant challenge as the bed nearest the fire exit would need to be moved and the pendent created an additional obstruction.

Following these concerns, we met with the fire officer and were provided with the unit’s fire assessment report from August 2017. We were also provided with a copy of the local fire evacuation plan, this had no date of when it had been produced or reviewed. These documents highlighted that the fire escape route we had concerns over was the third option for evacuation. Patients evacuated by this route would need to be moved on mattresses or sheets and the bed next to the door would need to be moved.

We were told there had been no recent scenarios to see how long it would take to evacuate a ventilated patient via this route. Eighty three percent of staff had undergone mandatory fire safety training however this did not include specific evacuation information for the ICU. We were assured that refresher information on the fire evacuation strategy would be shared with all staff; however, during the inspection staff were unsure about evacuation routes and plans within the unit.

Assessing and responding to patient risk

The critical care outreach team (CCOT) had provided cover seven days a week from 7.30am to 8pm at Scunthorpe General Hospital. Overnight cover was provided by the hospital out of hours team. It had been identified that there was a gap in service provision between the day team finishing and the night team starting. In response new shift patterns for both teams had been agreed. This would allow for continuous service provision and enable a handover between the day and night teams.

The trust used the national early warning score system (NEWS) as a tool for identifying deteriorating patients. The wards had an electronic system for recording patient observations. This allowed the CCOT to remotely view any patients with elevated NEWS scores. There was a clear escalation policy in place for when patients had an elevated NEWS score.

The CCOT played a vital role in supporting staff on the wards when patients become unwell. They attended cardiac arrest calls and provided support for patients requiring non-invasive ventilation until they could be transferred to ICU on the respiratory high observation bay. They also reviewed patients who were discharged from ICU to ward areas.

There was a nurse consultant for the deteriorating patient who managed the CCOT and some of the specialist nurses. The teams had a deteriorating patient dashboard. This enabled data to be analysed and if there were any wards or areas of concern there could be addressed by either further training or support for staff.
Sepsis screening tools and pathways were in use and mandatory training on sepsis had been introduced. Sepsis formed part of the ALERT course training for nursing staff. This had changed in February 2018 and incorporated a formal competency assessment with staff having to achieve a certain level to pass the course. This was to ensure through understanding and learning was achieved by staff.

Local safety standards for invasive procedures (LocSSIPs) had been revised and a central venous access device pathway had been developed. This brought together a number of policies and guidelines which had previously been separate documents. The standardisation of central lines had taken place so only one type was used. A database was also held of all central lines inserted to provide oversight and monitoring.

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

Staff we spoke with knew how to access the mental health support, however we were told often the crisis team would not attend the unit. We were given examples where mental health concerns were identified and situations had escalated. Staff felt specialist advice and support was needed but often not provided.

**Nurse staffing**

Northern Lincolnshire and Goole NHS Foundation Trust reported their staffing numbers below as of January 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post January 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>84.3</td>
<td>73.2</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital had a staffing fill rate of 86.6%, his means that the service had to function with 11.5 less WTE staff members than planned.

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 12%, for nursing and midwifery staff in critical care, which is higher than the trust overall target rate of 6.28%.

- Scunthorpe General Hospital: 12.8%

More recent data see on site showed the vacancy rate had reduced to 6.25%, however a further three whole time equivalent vacancies were soon to be added to this.

*(Source: Routine Provider Information Request (RPIR) - Vacancies)*

**Turnover rates**

From February 2017 to January 2018, Northern Lincolnshire and Goole NHS Foundation Trust reported an overall turnover rate of 8.9%, for nursing and midwifery staff in critical care, which is lower than the overall trust target turnover of 9.4%.

- Scunthorpe General Hospital: 6.3%
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From January to December 2017, Northern Lincolnshire and Goole NHS Foundation Trust reported a sickness rate of 5.0%, for nursing and midwifery staff in critical care; this was higher than the trust target of 4.1%.

- Scunthorpe General Hospital: 5.0%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

From February 2017 to January 2018, the trust reported a bank and agency usage rate of 55.1%, for nursing and midwifery staff, in critical care;

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Agency shifts</th>
<th>Bank shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses</td>
<td>255 (20%)</td>
<td>637 (50%)</td>
<td>84 (7%)</td>
</tr>
</tbody>
</table>

For both Qualified nurses and nursing assistant staff, Scunthorpe General Hospital had an agency staff usage rate of 20.1%, a bank staff usage rate of 50.1% and 6.6% of shifts were left unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Nurse staffing was based on guidance and standards from D16 NHS standard contract for adult critical care and GPICS. Nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients’ ratio for level two patients. Staff reported this could be impacted by staff being moved to support other areas in the hospital. Locally collected data showed between January 2018 and April 2018 staff had been moved on 53 occasions. However, we reviewed incident data from November 2017 to April 2018 and found no incidents related to staffing levels not being appropriate.

The nursing handover was led by the nurse in charge who then allocated staff to patients to ensure continuity of patient care and skill mix was considered. Nurses then completed a one to one handover at the bedside.

Planned and actual staffing numbers were displayed and were achieved during our inspection. Planned staffing levels for the unit were eight nurses on duty during the day and at night. Information on the trusts website showed fill rates during the day in October 2017 were 91%, however from November 2017 to March 2018 improved to between 97% and 100%. For the same time period, fill rates for night shifts were between 94% and 99%.

Electronic rostering was in place; we reviewed two weeks of rotas and found with the exception of three shifts there was a band six or seven nurse on duty. The planned numbers allowed for a supernumerary coordinator to be in place, this met GPICS guidance.

Vacancy rates and sickness did make staffing a challenge. Whist some posts had been recruited to there were still staff leaving the trust. Gaps in staffing were covered by agency staff or bank staff. Many of these shifts were filled by the unit’s own staff working additional shifts. From reviewing rotas, we were assured that staffing was in line with GPICS. The unit did not utilise...
greater than 20% of registered nurse from bank or agency on any one shift which weren’t their own staff.

The unit did not have a ward clerk. We observed the impact of this during our inspection. Staff had to answer the phone, add new admissions on to the computer system and complete other administration tasks which took them away from delivering direct patient care. At the previous inspection support had been available from a health care support worker from Monday to Friday. This was no longer in place. The unit did have a housekeeper who could provide some support; however, they were on leave during our inspection.

Managers reported good support from human resources with sickness management. Recruitment was ongoing and managers reported they were proactive with this as the recruitment process could be slow.

The CCOT consisted of four staff with one nurse on duty each day. Due to the size of the team, there could be gaps in service if there was annual leave or any sickness. The team aimed to provide a seven-day service. A recent uplift in staffing within the team had been approved which would have a positive impact.

Medical staffing

The trust has reported their staffing numbers below as at January 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post at January 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>31.8</td>
<td>34.2</td>
</tr>
</tbody>
</table>

Scunthorpe General Hospital has a staffing fill rate of 107.4%, indicating that the service had 2.36 more WTE staff members in post than was planned for.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

As from February 2017 to January 2018, the trust reported a vacancy rate of 3.1%, for medical and dental staff in critical care;

- Scunthorpe General Hospital: 3.3%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Critical care had a designated clinical lead. Since the last inspection the challenges remained in terms of recruitment of consultant intensivists, at the time of inspection there were five in post. A consultant was available during the day from 8am to 8pm supported by two junior doctors who worked from 8am to 6pm. Night cover had the same arrangement however the medical staff also had responsibility for theatres and obstetric emergencies. This meant GPICS recommendations were not fully achieved. However, all the nursing staff we spoke with confirmed a consultant was always available when needed, including out of hours.

It was also identified that consultant work patterns did not provide continuity of patient care as block working was not in place. This was also not in line with GPICS recommendations.

We discussed this with the service leads as this had been noted at the previous inspection. The team were clearly sighted on this. There was active ongoing recruitment to explore all avenues to fill vacancies.
In the eight patient records we reviewed we saw that twice daily consultant led ward rounds took place from Monday to Thursday. Daily ward rounds took place on Fridays and at weekends. This was an improvement from the last inspection however still not fully compliant with GPICS recommendations. The consultant to patient ratio was in line with the recommended range of 1:8 to 1:15.

In the 12 months prior to inspection there had been no use of medical locums in critical care.

**Records**

Nursing and medical records were stored in a trolley at the end of each bed space or outside the room of those patients requiring isolation. Information provided by the trust showed 89% of nursing staff in the service had completed information governance training against a target of 85%.

We reviewed eight sets of nursing and medical records in detail looking at care plans and risk assessments. Nursing records were accurate, fully completed and in line with trust and professional standards. Care bundles and pathways were in use for things such as pressure area care and indwelling lines. There was evidence in the notes we reviewed of holistic assessment which focused on details other than physical health needs, for example, mental health conditions.

Medical records were completed in line with trust and professional standards. We saw that patients were reviewed by a consultant within 12 hours of admission to critical care. This was in line with GPICS recommendations and was an improvement from the last inspection where names and grades of staff were not printed so this could not be evidenced.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital. A daily critical care assessment form was completed and on discharge from the unit a summary document was completed. This was done electronically and viewed on the trusts electronic patient management system. There was a focus on this as audit data showed improvement were required with the number of documents being completed.

CCOT staff confirmed that discharge information was thorough with clear escalation plans for individual patients.

We saw in a store cupboard that the review dates had passed on 10 blank documents stored there. This included; the falls care pathway, review date May 2013, intravenous drug chart, review date June 2013 and anaesthetic records, review date November 2013. We therefore lacked assurance that the most current documentation was being used. This would be an area of responsibility for administration staff, the lack of this could account for the finding.

**Medicines**

We reviewed five medicine charts and found these to be completed in line with trust and national guidance. Each of the medicine charts had been reviewed by the pharmacist and the allergy status had been completed. Each of the charts we reviewed had antibiotics prescribed; this was done in line with national guidance.

Up to date guidelines were at each bed space with information on drug compatibility and a flow chart to decide if sedation holding was appropriate.

During our inspection we found stock medicines within the unit were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We
reviewed controlled drug records and saw that accurate records and checks were completed in line with trust policy.

Fridge temperature checks had been completed daily from April 2018 up to the time of our inspection, including the temperature ranges. There was one episode of the fridge temperature going out of range. We saw evidence of escalation and appropriate action being taken.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported one incident classified as a never event in critical care.

The incident, a surgical invasive incident meeting SI criteria, took place in May 2017 at Scunthorpe General Hospital.

*(Source: Strategic Executive Information System (STEIS))*

The staff we spoke with were aware of the never event and the learning from it. We reviewed the investigation report and found a standard operating procedure had been put in place to response to the incident. All parts of the action plan had been completed.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust, apart from the never event described above, reported no further serious incidents (SIs) in critical care at this site which met the reporting criteria set by NHS England from March 2017 to February 2018.

*(Source: Strategic Executive Information System (STEIS))*

The unit reported 94 incidents between November 2017 and April 2018. One of these was graded as moderate harm and related to a staff member injuring themselves. The remainder were graded as low or no harm. Frequently reported incidents were pressure ulcers, out of hours discharges and the application of mitts to maintain patient safety. Senior staff had undertaken relevant training to investigate incidents.

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. There were various mechanisms for feeding back and sharing learning from incidents. This included information sharing at safety huddles after handover; on notice boards in the staff room and via email. Team meetings were also used to share information and learning, however due to sickness these had recently not taken place.

We reviewed monthly departmental governance meeting minutes and found incidents were a standing agenda item. The minutes also showed evidence of monitoring progress against serious incident action plans.

Allied health professionals told us that incidents were a standing item on their team meetings. They also said they would also be informed by the senior nurses if there had been an incident.
related to their service.

The electronic incident reporting system included a prompt on the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We saw information displayed in general areas on the duty of candour. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care. In the February 2018 performance report, we saw 100% compliance with duty of candour requirements.

Monthly critical care specific mortality and morbidity meetings took place, which was in line with GPICS recommendations. Feedback from consultants was this process was embedded within the unit. We were able to attend one of these meeting during our inspection, in which there was multidisciplinary attendance.

When the mortality and morbidity forum was established in 2015 a decision was made to review two cases with the lowest predicted mortality at the monthly meetings. Following further review of the standardised mortality rate for the year an upward trend was noted. Following this a decision was made to review of deaths within the hospital episode after admission to the ICU.

Structured judgement Training was provided for consultants to undertake reviews, the process had been modified to meet the needs of critical care. There were plans for reviews to be undertaken by multiple reviewers to reduce bias and to involve the high dependency unit in the process by the end of May 2018.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Safety thermometer data was collected by the sister on the unit. Safety information was displayed on the unit’s information board. We reviewed safety thermometer data for the unit which was variable this was due to the relatively small number of beds on the unit. We reviewed data from January 2017 to January 2018, where data had been captured on alternative months. The percentage of harm free care varied from 80% to 100%.

Compliance with VTE assessments was also monitored on the trusts divisional performance dashboard. Information from January 2018’s report indicated 100% had been completed for this unit; this exceeded the trust target of 95%.

**Is the service effective?**

**Evidence-based care and treatment**

The unit’s policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). Information from the April 2018 department governance meeting minutes showed compliance against NICE guidance was 86%.
Polices and guidance were accessed on the trust intranet which was easy to navigate. There was a critical care hub which contained policies relevant to the unit. This was shared between the two sites. We did find that old policies were not archived so searches could bring up several versions of the same policy which could be confusing. For example, when searching for the transfer policy it appeared to be past its date of review as the versions found were for review in 2012 and 2015. Staff felt sure there was a current policy but could not find it.

We reviewed 16 other polices and found them to be in date with an author and review date. Copies of frequently used guidelines and flow charts were also kept in folders at individual bed spaces. These were found to be current.

We saw evidence of screening for sepsis in the patient records we reviewed. At the previous inspection a new sepsis screening tool had been developed but was not in use. From reviewing records and speaking with staff we were assured this process was embedded. We were told an electronic sepsis screening tool was being trailed linked in with the launch of NEWS two, the latest version of early warning scoring.

Monthly data was collected on critical care outreach activity as part of CG50. CG50 relates to evidence-based recommendations on recognising and responding to deterioration in acutely ill adults in hospital. This included information on the number of referrals made and seen and the length of time taken to conduct an initial review. Data from April 2017 to March 2018 showed that 96.5% of critical care patients were followed up and 99.7% of new ward referrals were visited.

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

We also found that delirium screening had taken place for each of the patients we reviewed. This was also an improvement from the last inspection.

There had been a focus on care being delivered in line with NICE CG83 rehabilitation after critical illness since the previous inspection. Leaflets had been produced for patients and relatives and results of notes audit had highlighted the need for a short and comprehensive assessment tool. There were trials ongoing and changes being made to the assessment forms to make them user friendly whilst still capturing the required information. The current document had been streamlined and combined with physiotherapy documentation, we were told the initial feedback reading this revised document was positive.

### Nutrition and hydration

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw this had been completed in the eight patient records we reviewed.

The unit had a decision tree for nasogastric tube placements in adults and a standard operating procedure for checking placement by x-ray if normal processes are not available. There was access to an emergency feed protocol, this provided guidance for staff on feeding patients who were unable to eat and needed to be fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.

There was access to a dietitian and they would attend the unit each day. Staff told us if a referral was sent they would always come and review patients.

During our inspection we saw that water was available for those patients able to drink. Fluid balance charts were fully completed in each of the eight records we reviewed.
Pain relief

There was access to an acute pain team to provide advice; they worked with the multidisciplinary team. Pain relief was discussed on ward rounds and reviewed by the pharmacy team.

From the notes we reviewed we found evidence of pain scores being done and appropriate action taken in response to any indication a patient was experiencing pain. Each bed space also had a pain observation tool for patients who could not verbalise they were experiencing pain.

The patients and relatives we were able to speak with reported pain control being effective.

Patient outcomes

ICNARC Participation

ICNARC data was collected by a data clerk who worked closely with the clinical team to collate information.

The trust has two units, across two sites which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. More recent quarterly data may be available via the evidence grids. Any available quarterly data should be considered alongside this annual data. The critical care minimum data set was also collected for theatre recovery.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Scunthorpe General Hospital

Hospital mortality (all patients)

For the intensive care unit at Scunthorpe General Hospital, the risk adjusted hospital mortality ratio was 1.1 in 2016/17. This was within the expected range compared to the England average. The figure in the 2015/16 annual report was 1.1.

We reviewed data from the 1 April 2017 to 31 December 2017 quarterly quality report, this showed the risk adjusted hospital mortality was 1.07, this was within the expected range.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low risk patients)

For the intensive care unit at Scunthorpe General Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.8 in 2016/17. This was within the expected range compared to the England average. The figure in the 2015/16 annual report was 1.2.

We reviewed data from the 1 April 2017 to 31 December 2017 quarterly quality report, this showed the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.04, this was within the expected range.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The unit had an unplanned readmission rate within 48 hours of 2.1% for the period of 1 April 2017 to 31 December 2017. This was slightly higher than the rate for similar units which was 1.3%, however it was within the expected range when compared to the England average.
The physiotherapy team completed a national rehabilitation outcome measure called the 'Chelsea Critical Care Physical Assessment Tool', a scoring system to measure physical morbidity in critical care patients.

**Competent staff**

**Appraisal rates**

**Scunthorpe General Hospital**

The appraisal completion rate for staff within critical care at Scunthorpe General Hospital was 88.2%, lower than the trust target of 95%.

A split by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>44</td>
<td>50</td>
<td>88.0%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>51</td>
<td>88.2%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

All the nursing staff we spoke with confirmed they had undergone a recent appraisal. This was supported by up to date appraisal data we saw on site which showed compliance for nursing staff was 94%, which was just below the trust target of 95%.

We requested appraisal data for medical staff. This showed that compliance was 92%.

Information provided by the trust showed that 57% of nurses in the service had a post registration award in critical care nursing. This was a reduction from the last inspection where it had been 72%. This was a consequence staff vacancy and turnover rates; however, this still exceeded the GPICS minimum recommendation of 50%.

Since the previous inspection a clinical educator had been appointed who had been in post for 12 months. The clinical educator had oversight of all training and information was captured in a spreadsheet which we saw during our inspection. New staff to the unit, which accounted for 25% of the nursing workforce, were working to complete the national competency framework for adult critical care nurses.

Information was also captured on training for specific equipment such as tracheostomies and hemofiltration. Training for new equipment would often be delivered by company representatives, cascade training would then occur.

We saw an up to date transfer training and competency document and were told by the educator that staff would not accompany patients on transfers unless they had completed this. However, this information did not feed in to the staff rotas and we spoke with a number of staff who confirmed they had accompanied patients on transfers but had not undergone any training. We requested transfer training compliance data which showed 92% of staff had undergone inter-hospital transfer training. One Hundred percent of staff had undergone intra-hospital transfer training.
We saw the training board on the unit which detailed several study days available for staff on the unit and in the CCOT. This included; caring for the shocked patient, interpretation of blood results and renal failure. Staff within the deteriorating patient team played a key role in delivering training, for example the ALERT course which had been locally adapted and tracheostomy training.

The unit also had link nurses, for example, for tissue viability, who attended trust wide meeting and shared information with their peers.

Staff from the CCOT had clinical supervision with their manager. The staff were keen to develop themselves and the team however, some had to self-fund courses, for example prescribing and advanced practice.

All new staff both medical and nursing attended a corporate induction when starting at the trust. A local induction was completed by all new staff. There was a preceptorship programme in place and new staff would initially be supernumerary and were allocated mentors to work alongside. We spoke with some new staff members who said they felt well supported in their role.

**Multidisciplinary working**

We observed good multidisciplinary team working; this was supported by the staff we spoke with. We saw evidence of this in the eight patient records we reviewed. We observed the tissue viability team providing support with a complex wound dressing. There was access to speech and language therapy, a specialist nurse in organ donation and other nurse specialists when required.

There were clear internal referral pathways to therapy and psychiatric services.

Multidisciplinary staffing was generally in line with GPICS recommendations; however, it did not meet the full recommendations. There was not always full attendance during ward round however we saw from reviewing records there was daily input from the pharmacist and dietitian.

We spoke with physiotherapy staff who confirmed that in line with GPICS recommendations they were able to provide the respiratory management and rehabilitation components of care.

Microbiology input was variable; there was one consultant available five days a week. They were available as needed, but this may have been by telephone rather than in person. If this person was on leave access to microbiology advice was via a clinical pathology network operating across Lincolnshire.

We reviewed the units’ admission and discharge policy. This outlined the criteria for admission to the unit. We observed handovers taking place and the completion of transfer documents for patients going to ward areas. This was in line with NICE CG50 acutely ill adults in hospital. The critical care outreach team followed up all patients discharged to the wards from intensive care.

**Seven-day services**

We saw from patient records daily consultant led ward rounds took place. However, as discussed in the medical staffing section, this was not in line with GPICS recommendations, due to a lack of consultant intensivists.

A specialist critical care pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patients’ medicines. There was access to pharmacy provision on call at other times.

Physiotherapists provided treatment seven days a week with an on-call service was available overnight.
X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

**Health promotion**

Staff completed assessments on admission to the unit about patients’ individual needs and provided support as appropriate.

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Data was requested following the inspection on mental capacity training compliance for nursing and medical staff. The information provided by the trust showed 96% of nursing and 87% of medical staff were compliant with MCA training.

It was recognised that gaining consent within the unit could be difficult due to the patients they cared for. However, staff we spoke with demonstrated a good understanding of consent, and where possible, would always seek consent from patients.

In the records we reviewed there were daily prompts to undertake Richmond Agitation-Sedation Scale (RASS) scores and screening using the Confusion Assessment Method (CAM) for ICU. These are used to measure the agitation, sedation or delirium levels of a patient. We saw that where appropriate these had been completed and appropriate actions taken.

In the side rooms there was a camera in place to observe patients. These had no recording capability and there were signs clearly explaining this outside the rooms. The notice also explained the camera would be switched off when care and treatment were being delivered and we saw observed this during our inspection.

We spoke with staff about the use of restraint. Staff told us where possible this would be avoided; however, staff explained the process they would follow for the use of restraint and that they would complete an incident form. This was in line with trust policy. However medical and nursing staff were not clear about the assessment of mental capacity. They could not clearly articulate who was responsible for assessing capacity or how this would be done and where this would be documented. From reviewing incident data from November 2017 to April 2018 we found nine incidents related to mittens being applied. Five of these referred to an appropriate assessment being undertaken, however none of them made any reference to the assessment of patient capacity.

We reviewed a patient’s record where restraint was being used with mittens. It was documented in the medical and nursing notes that the patient did not have capacity. However, when questioned we were not clear how this decision had been reached as there was no evidence of, and staff were not able to describe, what assessment had taken place.

**Is the service caring?**

**Compassionate care**
The relatives we were able to speak with were positive about the care given. We were told they were very appreciative of the care and compassion demonstrated by the team on the unit.

We observed all members of staff providing care for patients' in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious. We observed a consultant telling junior staff about the importance of speaking to patients even if they are sedated and requiring ventilation.

We observed staff patiently and calmly communicating and reassuring a patient who was unsettled and attempting to remove their oxygen and monitoring.

Staff maintained patients’ privacy and dignity when care and treatment was being delivered by pulling curtains round.

We saw thank you cards displayed on the ward information board. This was updated each month. The cards displayed had heartfelt messages of thanks from families who had relatives who had been cared for on the unit.

**Emotional support**

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients. Information on this was seen in the relative’s coffee area.

The critical care outreach team said part of their role when reviewing patients on the ward following discharge from the unit was providing psychological support. Specialist nurses were also available.

Staff we spoke with felt able to provide support to relatives and well as to patients and felt this was an important part their role.

Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life.

**Understanding and involvement of patients and those close to them**

A guidance document had been produced for staff to support use of patient diaries. This included information on the overarching principles, how staff and relatives could make entries and examples of what to write and how to write it.

We saw information displayed on notice boards for relatives; there were also information leaflets available in the coffee area on areas such as infection prevention and pressure ulcer prevention.

We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.

The relatives we spoke with said they were ‘fully aware of the next steps’, another explained there had been regular visits by the dietitian and physiotherapist who had fully explained care plans to them.

We observed medical and nursing staff taking time to explain what was happening to relatives so they understood the care and treatment.

Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff had access to a specialist nurse for organ donation.
Is the service responsive?

Service delivery to meet the needs of local people

Critical care provision on the unit flexed to meet the differing needs of level two and level three patients. The critical care outreach team reviewed all patients who were discharged from intensive care to ward areas.

There was a coffee room for relatives; however, at the time of inspection the water fountain was out of order. A decision had also been made to stop relatives from using the kitchen to make hot drinks. If staff were unable to make drinks for relatives they would have to leave the unit to get one. There were no facilities for relatives to stay overnight.

The service did not have a critical care patient and relative support group.

The service had a follow up clinic in place. Patients were offered an appointment three months after discharge from the unit. The clinic was run by the critical care outreach team; if patient needs were identified referrals were made via their general practitioner. We were told the service was looking at providing consultant involvement with follow up clinics; however, no timeframes had been set to implement this.

Meeting people’s individual needs

Staff we spoke with knew how to access translation services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were kept in the trolleys at each bed space.

Staff we spoke with felt confident to care for patients with a learning disability or living with dementia. We saw evidence in patient records that care plans included assessment and interventions for patients with dementia, learning disabilities and delirium.

Staff recognised the importance of relatives and carers for any patients with additional needs. Staff would seek support from the nurse in charge if they had any concerns, or they could access specialist nurses.

The patient records that we reviewed reflected that individual needs were assessed and care planning was informed by this.

Patient diaries had been revised and relaunched the week before our inspection. Staff were encouraged to complete these for level three patients and any other patients who stayed on the unit for more than 72 hours. Evidence has shown these can provide comfort for patients following a stay on an ICU as they can fill in gaps and help patients understand what they have experienced.

Staff we spoke with told us they could access equipment to care for bariatric patients and this was always available when needed.

Access and flow

Bed occupancy

From January to December 2017, Northern Lincolnshire and Goole NHS Foundation Trust has seen adult bed occupancy slightly higher than the England average for the majority of months in the period.
Adult critical care Bed occupancy rates, Northern Lincolnshire and Goole NHS Foundation Trust.

![Graph showing bed occupancy rates](image)

Please note, data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Delayed discharges

For the intensive care unit at Scunthorpe General Hospital, there were 2,555 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 2.4%. This compares to the national aggregate of 4.9%, indicating that the unit was not in the worst 5% of units nationally. The figure in the 2015/16 annual report was 5.8%.

We were provided with the most recent ICNARC quarterly quality report. This showed that between 1 April 2017 and 31 December 2017 the bed days of care post eight-hour delay rate was 0.5% this was much better than similar units which had an average of 4.4%.

We asked staff about the process for when a patient was declared fit to transfer to a ward and staff told us the process was very proactive. If issues arose the matron could be contacted for support.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-clinical transfers

For the intensive care unit at Scunthorpe General Hospital, there were 475 admissions, of which 0.6% had a non-clinical transfer out of the unit. Compared with other units, non-clinical transfers for this unit was within the expected range. The figure in the 2015/16 annual report was 3.5%.

ICNARC data from 1 April 2017 to 31 December 2017 showed that of 327 admissions to this unit there were three non-clinical transfers (0.9%); this was in line with similar unit’s rates which were 0.8%. We found from reviewing incident data non-clinical transfers would be reported as an incident. Data from January 2018 to April 2018 indicated there had been two non-clinical transfers.

Further data from the trust showed the number of non-clinical transfers was reducing. In the 2015-2016 there had been 19 compared to five in 2016/2017.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-delayed out of hours discharges to the ward

For the intensive care unit at Scunthorpe General Hospital, there were 224 admissions of which 4.5% were non-delayed, out-of-hours discharges to the ward. These are discharges which took
place between 10:00pm and 6:59am. Compared with other units, the unit’s performance was within the expected range. The figure in the 2015/16 annual report was 3.9%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The decision to admit to the unit was made following a discussion between the critical care consultant and the consultant or doctors already caring for the patient. From the eight sets of notes we reviewed all the patients had been reviewed by a consultant within 12 hours of admission. This met the GPICS standard.

Data provided showed there had been 22 cancelled operations in 2016/2017 due to their being no ICU bed. To support access and flow the hospital had been trialling a 23-hour recovery bed to support patients following major surgery who may require an extended recovery period but not necessarily admission to ICU. Additional staffing had been provided to support this additional service and initial feedback was that it had been successful.

Learning from complaints and concerns

Summary of complaints

Scunthorpe General Hospital received four complaints, two about waiting times, one about patient care and one about values and behaviour. The unit took an average of 24 days to investigate and close complaints which is in line with the trust complaints policy which states that complaints should be investigated and closed within 30 days.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Information was available to patients and relatives on how to make a complaint.

Staff were aware of the policy for managing concerns. However, all staff said they would try and resolve any concerns at the time they arose. Often this may be dealt with by the nurse in charge.

Complaints and information from the patient advice and liaison service were standing agenda items on the departmental governance meetings. We reviewed minutes from January 2018 to April 2018, there were no areas of concerns identified which related to critical care.

Is the service well-led?

Leadership

At the previous inspection there had been changes to the senior management team, since then there had been further changes. Clinical directors had been appointed and had oversight of the directorate, they were supported by an operational director and operational chief nurse. These changes supported an improvement in clinical oversight and ownership. The team was positive about the changes and felt even prior to the changes they had been working towards this model.

There was a lead consultant and a lead nurse for critical care. Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards.

From discussions with the leadership team it was clear they understood the current challenges and pressures impacting on service delivery and patient care. There were plans in place to address gaps and areas of non-compliance with GPICS standards, however the team accepted the significant challenges with regards to medical staffing.
The leadership team and senior staff were visible and approachable. There was strong nursing and medical leadership on the unit. From our observation and from speaking with staff, it was clear that staff had confidence in the leadership. Staff reported feeling very supported by their teams and managers and able to escalate any concerns.

Senior nurses were extremely positive about the service and very proud of all the staff and the quality of the care they provided for their patients and families.

**Vision and strategy**

The vision for the unit was ultimately dependent on the long-term reconfiguration of critical care services across the two hospital sites and Scunthorpe and Grimsby. The hope was for a combined unit with additional capacity at this site.

We spoke about the strategy for the service with the senior management team and were provided with the critical care future configuration options appraisal which formed the emerging view of the trusts critical care strategy. This was based on a review of data to inform what future services would need to look like to support patients requiring critical care admission.

The information in the document showed an understanding of the local and wider critical care requirements and the options considered were based on a review of activity within the two units.

There was and continued to be a focus on CG83, guidance on rehabilitation after critical illness, as well as looking at the completion of staffing competencies and developing the skills of the workforce.

There was also a focus on access and flow to continue to try and reduce out of hours discharges and non-clinical transfers from the unit.

**Culture**

Staff told us they felt proud of their work and the care they provided to patients and their relatives.

We observed a supportive and open culture, where nursing, multi-disciplinary and medical staff were approachable and valued each other’s opinions.

Staff of all we spoke with told us they felt able to raise concerns and were aware of the importance of being open and honest to patients and relatives if there had been a mistake in their care.

Whist we found morale within the nursing team was generally good, we found one area causing dissatisfaction amongst staff was movement to other areas. This was also found at the previous inspection. Staff felt they were moved to ward areas but the help was never reciprocated, and there was often not a full appreciation of the dependency and nursing input required to care for the patients that were on the unit.

Staff also told us that how the decision to move staff was communicated to them by the site management team was unacceptable. We spoke about this with senior nursing staff and a meeting was due to be held to try and resolve some of these issues which staff saw as a positive step.

Some staff fed back that the lack of continuity of consultant cover led to some inconsistencies in terms of decision making and at times meant they had to provide additional support to families as a consequence of this.

**Governance**
Governance processes had changed since the last inspection, whilst these were still relatively new, it was felt this positive and that governance would be strengthened.

The directorate had established a surgical management board. This was clinically led with each speciality giving an update so each one was sighted on each other’s issues. Weekly meetings also took place between the business manager, the matron and the clinical lead for critical care. We reviewed meeting minutes which had standing agenda items related to risk, incidents and complaints.

The information was disseminated to staff via team meetings, however it was identified that due to sickness these had not been taking place. Senior staff were aware of this and planning to re-establish these.

Information was also shared at safety huddles which took place each morning after handover.

Management of risk, issues and performance

There was a divisional risk register which contained 45 risks; three of these were specific to critical care at this site. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Each of the risks had been recently reviewed and updated. There was a description of the risk with associated controls and action plans.

The risks related to consultant staffing, hemofiltration equipment needing replacement and capacity within the outreach service to provide a twenty-four-hour, seven day a week service.

From our discussions with the leadership team they were clear about any risks to the service and mitigating actions and the risk register reflected this.

The previous inspection had found some gaps in terms of rehabilitation following critical illness. Within the unit there had been a significant amount of work to improve this. This included a relaunch of patient diaries. This had been very recent; however, time had been taken to ensure a useable comprehensive document with supporting information for relatives. Work was also ongoing with regards to clinical assessments and how best to capture this information. There were also plans to try and have medical input into the follow up clinics.

Dashboards for deteriorating patients and sepsis were in place. This allowed for monitoring and targeted interventions based on the data.

Information management

The admission, discharge and transfer documentation was in line with best practice and NICE guidance.

Staff received training on information governance and were aware of the importance of managing confidential patient information. We found that records were stored securely within the unit.

Blood results, x-rays and scan results could be accessed electronically, mobile workstations allowed these to be reviewed at the patients’ bedside.

Engagement

Friends and family test data as for all critical care units was limited, so results could not be collated or analysed. We saw leaflets for patient and visitor feedback in the relative’s coffee lounge. This asked five questions about the care and treatment their relative received whilst on the unit with space for any additional comments.
In addition, ten patients were asked each month how they felt they were treated. The most recent data showed 100% of those asked said their needs were met.

Information was displayed on ‘you said’ ‘we did’ in response to patient feedback. The recent comments displayed were positive and were about staff treating ‘the person’ and that was what made the team special. The response was that the unit aimed to always give person centred care to the highest standard.

Some feedback was gained from the follow up clinics and through patient diaries. However as described these processes were still being further embedded.

The staff we spoke with felt involved and informed about what was happening in the trust. We reviewed meeting minutes which evidenced discussions around incidents, training and staffing with senior staff. Staff spoke about safety huddles for sharing information and we saw several notice boards that were used to share information on a wide range of topics including the latest ICNARC data.

There was also a board describing what the team were proud of. This included achieving platinum accreditation and the support the team provides to each other. Areas the unit were working to improve were listed as rehabilitation and patient diaries, patients sleep patterns and team spirit.

**Learning, continuous improvement and innovation**

The service was actively involved in the regional critical care operational delivery network.

A significant amount of work had been done on rehabilitation after critical illness and this work was ongoing.

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

Local safety standards for invasive procedures (LocSSIPs) had been developed for central venous access devices. A database was also held of all central lines inserted to provide oversight and monitoring.

The trust was an early implementer of the NEWS two pathway, which provides improved safety and clinical outcomes for acutely ill patients.

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

Facts and data about this service

The trust has 70 inpatient paediatric beds across its two sites:

- Scunthorpe General Hospital has 18 inpatient beds, including two high dependency beds, on Disney Ward. There are also 16 cots, including four transitional care cots, on the neonatal unit.

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute tab)

The trust had 3,775 admissions otherwise known as spells from December 2016 to November 2017. Emergency spells accounted for 95% (3,584 spells), 4% (152 spells) were day case spells, and the remaining 1% (39 spells) were elective.

Percentage of spells in services for children and young people by type of appointment and site, from December 2016 to November 2017, Northern Lincolnshire and Goole NHS Foundation Trust.

![Percentage of spells chart]

Total number of children’s spells at trust level and by site, Northern Lincolnshire and Goole NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>2,049</td>
</tr>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>1,720</td>
</tr>
<tr>
<td>This trust</td>
<td>3,775</td>
</tr>
<tr>
<td>England total</td>
<td>1,099,209</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)
Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for medical staff in services for children and young people is shown below:

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>18</td>
<td>22</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>18</td>
<td>22</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>17</td>
<td>22</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>16</td>
<td>22</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>13</td>
<td>22</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>12</td>
<td>22</td>
<td>55%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>11</td>
<td>22</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>10</td>
<td>22</td>
<td>45%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>8</td>
<td>22</td>
<td>36%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>6</td>
<td>22</td>
<td>27%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff at the trust did not meet the completion target for any of the courses at any of the sites.

A breakdown of compliance for mandatory courses February 2017 to January 2018 for qualified nursing and midwifery staff by site is shown below:

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>45</td>
<td>47</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>45</td>
<td>47</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>43</td>
<td>47</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>42</td>
<td>47</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>42</td>
<td>47</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>40</td>
<td>47</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>35</td>
<td>47</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>30</td>
<td>47</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>18</td>
<td>29</td>
<td>62%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>24</td>
<td>47</td>
<td>51%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The 85% training target was met for six of the 10 modules offered to nursing staff at both Diana Princess of Wales Hospital and Scunthorpe General Hospital.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Following our inspection, we requested up to date mandatory training figures for April 2017 to March 2018. These showed that overall compliance with mandatory training within children’s services at the trust was 65% for medical staff and 83% for nursing staff. However, these figures were not broken down by site or subject. Medical staff in children’s services were therefore not meeting the trust target of 85% compliance for mandatory training.

Discussions with staff confirmed they could access online learning, however, some of this was not relevant to paediatrics and neonates. For example, adult sepsis was included within the mandatory training they completed.

The band five and six staff we spoke with said they had completed their online compliance matrix and that they were up to date with their training. They told us they had also attended classroom-based training, which included moving and handling, tissue viability and infant feeding.

Staff we spoke with told us the central training database was not up to date and mandatory training records were not kept locally. The deputy ward manager from the neonatal unit ensured staff attendance at mandatory training through allocation of mandatory training sessions through the staff rota.

Safeguarding

The executive lead for safeguarding children and adults was the chief nurse whose responsibility was to ensure robust and effective arrangements for safeguarding adults and children within the trust. The head of safeguarding was the strategic lead and manager of the safeguarding team. The safeguarding team’s remit included, safeguarding children, safeguarding adults, looked after children, PREVENT, Mental Capacity Act and Deprivation of Liberty. A consultant paediatrician was the sudden unexpected death in children (SUDIC) lead; supported by a SUDIC nurse.

Safeguarding reporting arrangements were in place to ensure safeguarding processes were monitored trust wide.

The safeguarding team’s contact details were displayed within clinical areas. The information included photographs of the head of safeguarding, three named nurses for safeguarding children, the specialist safeguarding nurse and the named midwives for safeguarding children.

Members of the safeguarding team were involved in the development of the Child Sexual Exploitation (CSE) Strategy for North East Lincolnshire’s Local Safeguarding Children’s Board as well as the ‘Keeping Children Safe Meetings’, which oversaw and challenged the work of the CSE operational group.

Staff we spoke with in the community nursing team told us that they attended safeguarding strategy meetings and court sessions. Following attendance at court sessions, the community staff said they wrote court reports.

Policies and procedures included references to multi-agency policies and procedures. The trust had a safeguarding children’s policy, a domestic abuse policy and a female genital mutilation (FGM) guideline.

Reporting of FGM through disclosure or diagnosis was forwarded to the safeguarding children’s team & the lead professional. Concerns in relation to safeguarding children were shared with the
multi-disciplinary team, which included the GP, practice nurse, health visitor and school nurse. We saw posters displayed, which highlighted the responsibilities of individual practitioners to report cases of FGM in someone below 18 years of age to the police.

Staff we spoke with demonstrated knowledge of the safeguarding guidance to follow. They knew what to do and who to contact should a concern be raised. Staff confirmed that feedback was received and lessons learnt from individual safeguarding incidents.

Safeguarding children drop in sessions for domestic abuse were displayed in the Disney ward education room. We saw two sessions identified for monthly safeguarding supervision. Safeguarding procedures were communicated to staff through training attendance and during safeguarding supervision.

Staff accessed safeguarding supervision sessions held by the safeguarding nurses. Following our inspection, we requested evidence from the trust of staff attendance at safeguarding supervision. For medical staff we saw that eight out of 26 were not up to date with their safeguarding supervision. We did not receive any evidence related to nursing staff attendance.

Staff we spoke with told us that when children or young people did not attend appointments a form was completed, if this happened three times the safeguarding team was contacted. However, the safeguarding team were contacted earlier if any concerns were raised prior to this.

The electronic patient record systems flagged alerts of children and young people under child protection plans or who were looked after children. Staff we spoke with told us that they liaised with the child’s social worker where the child was a looked after child to confirm visiting rights and parental responsibility.

Systems were in place to support teenagers. We reviewed one young person’s notes admitted under the children’s and adolescent mental health team. We observed appropriate safeguarding and multi-agency referrals were made to support this young person.

At our last inspection, we said the trust must ensure there were effective processes in place to support staff and that staff were trained in the recognition of safeguarding concerns. All staff were required to complete safeguarding adults training and safeguarding children in line with the intercollegiate document for ‘Safeguarding Children’. The intercollegiate document, Safeguarding Children and Young People: Roles and competencies for Health Care Staff (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level three in safeguarding. The training figures below were provided by the trust prior to our inspection.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical staff in services for children and young people is shown below:

<table>
<thead>
<tr>
<th>Scunthorpe General Hospital</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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At Scunthorpe General Hospital, safeguarding children level three was the only module where the 85% target was not met.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for qualified nursing staff in services for children and young people is shown below:

### Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>35</td>
<td>47</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>44</td>
<td>47</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>44</td>
<td>47</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>41</td>
<td>47</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At trust level and at Scunthorpe General Hospital, safeguarding adult’s level one was the only one of the four modules for which qualified nurses were eligible where the 85% target was not met.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Following our inspection, we requested up to date safeguarding training level three figures. The trust provided the information below to show that between April 2017 and March 2018, compliance was:

<table>
<thead>
<tr>
<th>Ward and Department</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>208 SGH Critical Care Ward Nicu (2650)</td>
<td>4</td>
<td>27</td>
<td>87%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>208 SGH Medical Staff Paediatrics (3717)</td>
<td>4</td>
<td>8</td>
<td>67%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>208 SGH New Born Hearing Screening (2652)</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>208 SGH Paediatric Nursing Community and Outreach (2657)</td>
<td>1</td>
<td>20</td>
<td>95%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>208 SGH Paediatric Outpatient Department (2654)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>208 SGH Paediatric Wards (2653)</td>
<td>2</td>
<td>35</td>
<td>95%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical staff were therefore not meeting the trust target for compliance with level three safeguarding training.

**Cleanliness, infection control and hygiene**

Clinical areas within children’s services were visibly clean. Hand gel pumps, gloves, aprons and washbasins were located throughout the clinical environment including entry and exit points to clinical areas. Staff throughout the children’s and neonatal service observed infection control techniques.
practices in line with trust policy. These practices included handwashing, bare below the elbow and the use of hand gel between patient contacts.

Staff we spoke with told us that they could easily contact the infection control team, which meant appropriate professional advice was available.

Cleaning schedules were in place, which identified the tasks and frequency of cleaning in each area. Discussions with staff confirmed that nursing and ward assistants had specific roles in relation to cleaning duties. Within children’s services, play therapy staff or nursing staff cleaned toys. Toys in the adult ophthalmic clinic were dirty and no cleaning schedule was in place; this was escalated to staff at the time of the inspection.

We observed waste guidance displayed in clinical areas.

Staff received infection prevention and control training as part of their induction and as part of the annual mandatory training. Nursing staff met the trust target for compliance with 89% compliance; however medical staff only achieved 55% compliance.

Hand hygiene audits between April 2017 and April 2018 for the children’s ward, showed 100% compliance for most months, apart from April 2017 which was 96%, June 2017 which was 90%, March 2018 was 87% and April 2018 was 98%. The neonatal unit achieved 100% between April 2017 and April 2018. There were no results available for the paediatric outpatients department in 2018, but in 2017, compliance was 100%.

Local cleaning audits showed that all areas were meeting the target of 95%

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.8 out of 10 for question 6, ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts. This question was asked of parents and carers of children up to 15 years of age.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Environment and equipment**

We reviewed the paediatric resuscitation trolleys on Disney ward, the paediatric high dependency area, children’s clinic, ear nose and throat and fracture clinics, x-ray and the emergency department. There was no standardisation of paediatric resuscitation trolleys; numbered tags were not used to secure all trolleys in all areas. Equipment checklists were individualised in some areas and some laminated which meant there was no previous documentation and confirmation that checks were satisfactory to compare against. We reviewed the trust resuscitation policy (DCP137, v3), to ascertain whether the equipment checklist we saw complied with the resuscitation checklist. We were unable to access this information, as the link from Appendix B within the policy did not exist.

The neonatal peer review (2017) identified the closure of one nursery in the neonatal unit because of the presence of pseudomonas in the tap water. Following this, the pipes and sinks in both rooms were replaced. One room had reopened which meant that the additional cots in the special care baby unit had been removed.

Staff we spoke with told us that the neonatal units’ temperature was controlled centrally. To alter the temperature estates were contacted. Room heaters were used when needed overnight. One parent we spoke with told us that they were reluctant to give their baby skin to skin contact as the
room was too cold. The temperature on the neonatal unit had been identified as a risk on the risk register.

Equipment suitable for babies, children and young people was available in all clinical areas. Painted murals were seen throughout children’s areas.

Throughout our inspection, we undertook checks on clinical equipment and noted equipment was serviced; this was denoted by the presence of a sticker.

The children’s unit comprised of 18 beds, which included a two-bed high dependency unit. A dedicated adolescent room was available where young people could go.

The neonatal unit operated 16 cots. Included within the cot numbers were two side rooms and a combined intensive care unit and high dependency unit.

The children’s outpatient department (COPD) had a treatment room and five consultation rooms. One room when not in use was used to accommodate children and their families when they needed some alone time.

Entry to the neonatal unit and Disney ward was via an intercom system. This maintained the safety and security of the babies and children on the unit. CCTV was in operation and visitors were asked who they were.

At our previous inspection, we said the trust should ensure an appropriate environment and staff are available for children and young people receiving anaesthesia and recovering from surgery, in accordance with national guidance. At this inspection, we found the theatre recovery at Scunthorpe General Hospital was a shared four-bedded recovery with adult patients. There was one dedicated recovery space for children and young people. In recovery, children and young people were separated from adult patients by a curtain or decorated paediatric screens. One sick children’s nurse worked part-time in theatres, however, currently no sick children’s nursing support was provided in theatres.

**Assessing and responding to patient risk**

At our last inspection we said the trust must continue to improve its paediatric early warning score system to ensure timely assessment and response for children and young people using the service. The paediatric early warning score (PEWS) was used to monitor children at risk of deterioration by grading the severity of their condition and prompted nursing staff to get a medical review at specific trigger points. We saw ongoing discussion of children’s PEWS status take place through safety huddles. Discussions with staff about PEWS escalation and the review of four children’s PEWS scores confirmed appropriate escalation had taken place in respect of those children.

The trust had an electronic observation system, accessed through hand held computer devices and laptops across hospital sites. The children’s service used a mixture of electronic and paper recording. At the time of the inspection, the paediatric early warning score was recorded on paper. However, we were told that staff in the future would be able to enter PEWS scores electronically.

The PEWS chart had been in use in the service since 2009 and used a colour-coded warning; however, following the identification of a number of risks with this system, the trust changed this to a point scoring system in line with regional and national practice. The new PEWS system included new, age specific charts to record the observations, training for all staff for recording observations in children, a safety huddle at 9am and 9pm on the paediatric wards and a supervisory nurse in charge each shift on the ward. Following this change in practice, an audit to assess compliance with the new system was planned but a date for this had not been confirmed.
The safety huddles, which took place twice daily, included medical and nursing staff. We observed a morning safety huddle on Disney ward and noted some of the discussions included the identification and progress of the deteriorating child, triggering of the paediatric early warning score (PEWS) and admission of CAMHS patients.

Sepsis information in poster format was displayed in clinical areas. The information on the sepsis poster identified symptoms of sepsis. Parents, visitors and young people were able to access information leaflets, which described ‘Sepsis in Children’. The information leaflet explained what sepsis was, its diagnosis and treatment. In addition, we saw age specific sepsis screening and action tools were used.

We reviewed four children’s notes to track the sepsis management pathway so that we could ascertain whether appropriate escalation and management of sepsis had taken place. One baby’s notes showed prompt management of the septic episode had taken place. However, when the PEWS score was six, although escalated as per protocol, observations were not completed in line with trust guidance.

Risks to babies on the neonatal unit were identified during initial assessment and documented within care plans. Ongoing reviews of babies’ risks took place. At shift handovers, safeguarding issues and specific risks were discussed with incoming staff.

Staff competencies in recognising the sick child were enhanced through attendance at training sessions. Staff could access ongoing training; training dates were throughout 2018. The subjects included within the training were sepsis, airway skills, fluid management, drug calculations, and recognition of the subtle changes and differences in the deteriorating child. The recognition of differences between paediatric and adult patients was also included.

The trust worked with retrieval services for children and neonates whose role was to transfer sick babies and children to the paediatric and neonatal intensive care units based in other centres.

Two high dependency unit (HDU) beds were located on Disney ward. Staff who worked in the HDU were advanced paediatric life support (APLS) trained. This group of nursing staff were managed and supported by a band six nurse who had completed the APLS training which was about to be renewed. This meant that full Royal College of Nursing Staffing (2013) guidance was not met in relation to the senior nurse who led the HDU area.

Staff we spoke with told us there was no dedicated safe room, which had been ligature assessed on Disney ward. The service needed to develop and undertake an adolescent mental health risk assessment, to support vulnerable children and young people whilst in hospital.

The trust did not have paediatric specific theatre lists. During our inspection, we tracked two children through theatre and observed surgical safety checks were completed appropriately.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 7.7 out of 10 for question 20, ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts. This question was asked of parents and carers of children up to 15 years of age.

**CQC Children and Young People’s Survey 2016 questions, safe domain, Northern Lincolnshire and Goole NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
</table>

---

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Q20. Were the different members of staff caring for and treating your child aware of their medical history?

| 15 adults | 7.7 | About the same as other trusts |

*0-15 adults = asked of parents and carers of children up to 15 years of age.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Nurse staffing

Staff told us there was not a designated nursing lead for children’s surgery in the trust. At our last inspection, we said the trust must ensure appropriate numbers of staff, both medical and nursing are available in line with national guidance and patient acuity and dependency in paediatrics. Staff we spoke with told us staffing had improved since the last inspection. However, staffing shortfalls existed in the assessment unit because only one trained nurse and one healthcare assistant worked in the unit during opening hours. The Royal College of Nursing (RCN) staffing guidance (2013) states that there should be two whole time equivalent registered children’s nurses working in an assessment unit throughout the opening hours.

Staffing within the children’s service was considered safe by the senior management team and staff who worked throughout the service. However, it was recognised that staffing levels were reduced at nights, which could constitute a risk to the service. Staff said the risk was mitigated through the employment of additional staff when required and close cross site working with the paediatric service at Diana, Princess of Wales Hospital in Grimsby.

A business case had been approved for an increased number of nursing staff. Following a 12 month audit, the service had adopted a 1:4 care model, as the audit showed that they had more admissions of children over two years of age than under two years of age. The RCN guidance recommends staffing ratios of 1:3 for under two year olds and 1:4 for over two year olds. We requested staff rotas to check compliance with the guidance, however we were not sent a complete rota to be able to check compliance.

Patient acuity was documented using the ‘Safer Care Tool’, however, monitoring through this tool had ceased at Scunthorpe General Hospital children’s service. Patient acuity was monitored through safety huddles at the start of shifts and by the paediatric early warning score, introduced two months previously. Staff said that additional ward rounds took place when patient capacity had increased and additional support accessed either through a senior manager or at night the site manager.

Safety huddles attended by the multi-disciplinary team took place twice daily within children’s services. On Disney ward, we saw a completed safety huddle document, which identified a list of alerts for discussion. The document was a tool, which ensured a full and effective handover between medical and nursing staff. During a safety huddle attended by medical and nursing staff the paediatric ward was rated ‘Green’ status for staffing on the 10 May 2018. This meant that staffing levels against patient workload were considered safe at that moment in time. This process demonstrated that staffing levels were reviewed to mitigate risks to the service regularly.

Staff we spoke with told us that their own staff, bank and agency filled staffing shortfalls; however, from February 2018 onwards the service had not employed many temporary staff. Staff said additional support had been accessed from the neonatal unit and vice versa. Staff said they also provided staffing support to the paediatric service at Diana, Princess of Wales Hospital in Grimsby.

A community specialist nursing team provided care for children in the community. The team comprised of specialist nurses for conditions, which related to respiratory, complex needs, diabetes, endocrine, oncology and attention deficit hyperactivity disorder. The team comprised of one whole time equivalent (wte) nurse for each speciality, except for diabetes where two wte nurses provided support in this area.
One interim band seven nurse was based on Disney ward. This nurse told us that they worked in a management capacity and would assist clinically when required.

Since our last inspection, there had been an increase in the number of band six nurses.

On Disney ward, just over one whole time equivalent vacancy existed.

Whilst on inspection, we reviewed staffing rotas looking at band 6 nursing cover. We saw that in January 2018, there had been no band six nursing staff working in a supernumerary role, however in March and April 2018, we saw an improvement in the number of band six nursing staff and they were working supernumerary for the majority of shifts.

Children’s and neonatal areas had a ‘staff on duty today’ board, which identified planned and actual staffing numbers on shift.

Band five and six staff nurses who were advanced paediatric life support (APLS) worked within the high dependency area, supported by a band six nurse. All except four newly qualified nurses had completed APLS training. Staff we spoke with told us that there was always an APLS trained nurse on shift.

We were told that staff attended the emergency department (ED) to support ED staff and sick children. However, staff told us that in situations where Disney ward’s acuity was high, staff would not attend the emergency department.

**Neonatal staffing**

Senior nursing staff confirmed that neonatal staffing funded establishment did not fully meet the British Association of Perinatal Medicine (BAPM) Guidelines (2011).

We reviewed staffing information on the electronic system. This showed where BAPM guidelines were met and any shortfalls. From 1 March 2018 to 30 April 2018, the percentage of shifts staffed to BAPM recommendations was 85.25% against a national average of 66.46%. The percentage of shifts qualified in speciality was 80.33% against a national average of 78.59%. The average nurses on shift were 4.95 and the average nurses required per shift was 4.11. The additional nurse shifts required to make all shifts compliant were 7.3 shifts.

From 1 March 2018 to 30 April 2018, the percentage of shifts covered by bank staff was 7.12% against the national average of 6.61%.

All but three band five staff had qualified in the speciality; currently, two band five staff were completing the neonatal course.

Risk assessments took place regularly through safety huddles completed at each handover. The safety huddles included information about cot occupancy, acuity levels of babies and staffing information. Each handover was rag rated and additional information, which included safeguarding, potential discharges, and patients causing most concern was discussed.

The trust has reported their staffing numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan 18)</th>
<th>Actual WTE (Jan 18)</th>
<th>Planned WTE (Jan 17)</th>
<th>Actual WTE in month (Jan 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>38.9</td>
<td>36.5</td>
<td>38.9</td>
<td>36.9</td>
</tr>
</tbody>
</table>
The trust reported that across both sites 98.9% of qualified nursing posts were filled as of January 2017, and 99.5% as of January 2018. Scunthorpe Hospital was reported to be close to establishment in both months.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

Annual vacancy rates for qualified nursing staff in services for children and young people from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>2.4</td>
<td>38.9</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

*Negative numbers indicate a staffing surplus

The trust reported staffing 3.7% above establishment for qualified nursing staff in services for children and young people, driven by a surplus of 7.3% at Diana, Princess of Wales Hospital. Both sites met the trust’s target of 6.3% for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Annual turnover rates for qualified nursing staff in services for children and young people from February 2017 to January 2018 are shown below, at trust level and by site. Please note, staff in the trust’s safeguarding and looked after children team were not mapped to a hospital site in the trust data and are shown here under trust wide.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>1.0</td>
<td>36.5</td>
<td>2.7%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>1.0</td>
<td>11.0</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 7.8% for qualified nursing staff in services for children and young people, which was lower than the trust’s target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Sickness rates for qualified nursing staff in services for children and young people from January 2017 to December 2017 are shown below, at trust level and by site.
The trust had an annual sickness rate of 4.9 for qualified nursing staff in services for children and young people, which was higher than the trust's target of 4.1%. Both reported sites did not meet the trust target for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0 (0.0%)</td>
<td>84 (68.9%)</td>
<td>15 (12.3%)</td>
<td>122</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>98 (13.2%)</td>
<td>234 (31.5%)</td>
<td>198 (26.6%)</td>
<td>744</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018 a total of 794 nursing shifts were filled by bank or agency staff in services for children and young people, which represented 38.3% of all available shifts. Over this period 22.8% of all shifts remained unfilled.

Over the same period at Scunthorpe General Hospital, there were 416 nursing shifts filled by bank or agency staff in services for children and young people, which represented 48.0% of all available shifts. Over this period 24.6% of all shifts remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical staffing**

The children’s service confirmed that they were not compliant against the Royal College of Paediatric and Child Health (RCPCH) ‘Facing the Future’ standards because of a lack of permanent consultant cover between 5pm and 10pm. Senior medical staff said consultant staff often stayed onsite rather than go home in the evenings so they could respond quickly to situations.

The service employed seven whole time equivalent (wte) consultants within the acute children’s service, which meant they had not achieved the ‘Facing the Future’ standards for Consultant cover, identified as ten whole time equivalent consultants.

The standard that a consultant saw all patients within 14 hours and at peak times was not achieved. This was because consultants worked from 9am to 5pm Monday to Friday, with less consultant cover at weekends. Doctors’ rotas confirmed the consultant of the week and on call consultant’s availability.

Medical staffing establishment did not fully meet the British Association of Perinatal Medicine (BAPM) Guidelines (2011). The requirements for a local neonatal unit were a minimum of seven paediatric/neonatal consultants on the on-call rota. The trust had five consultants in post. We observed that the doctors’ rotas confirmed one consultant of the week and one on call consultant for the neonatal and paediatric service. This meant there was a potential risk to one service if the consultant was required for both services at the same time. The neonatal service was not compliant against BAPM medical staffing guidelines because a tier one doctor rather than a tier two doctor supported the neonatal unit on night shifts. From 9pm to 8.30am one night resident
registrar and tier one doctor cross-covered the neonatal unit & paediatric ward. A new neonatal lead was due to start in post.

The medical rotas dated from 2 April 2018 to 3 June 2018 showed consultant of the week (CoW), on-call consultant cover, registrar and senior house officer cover in place for Disney ward and the neonatal unit. The rota confirmed consultant level support was in place for seven days of the week from 9am to 5pm. The consultant of the week covered the neonatal unit.

Daily ward rounds took place on Disney ward. Staff told us that generally the paediatric consultant on-call attended the 9pm handover.

Twice weekly ward rounds took place on a Monday and Friday on the neonatal unit. The remaining days the consultant of the week reviewed the decisions made on the neonatal ward round by the registrar doctor. A formal ward round did not take place and not every baby was seen by a consultant daily. The Neonatal Peer Review took place in November 2017. The review identified a lack of consultant presence on the neonatal unit and a lack of senior support for nurses, junior doctors and families was noted.

Staff we spoke with told us that there was a good medical presence and support throughout the service. Consultant staff were described as supportive and provided support to the service out of hours. Junior medical and nursing staff we spoke with told us they had been able to access consultant or registrar level doctors when needed.

A designated surgeon was not identified with a responsibility for children’s surgical services throughout the trust. However, a lead anaesthetist with a paediatric interest provided support from an anaesthetic perspective. Staff identified surgeons as friendly, although, they did not always receive the support required which included difficulties in contacting them.

We observed a medical handover session on the neonatal unit. The handover was concise and information was reviewed systematically.

The trust reported their medical staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>20.7</td>
<td>20.7</td>
<td>20.7</td>
<td>20.7</td>
</tr>
</tbody>
</table>

The trust reported that across all three sites, 100.2% of medical posts in services for children and young people were filled as of January 2017. By January 2018 this had declined to 92.3% of posts filled.

As of January 2018, the fill rate was approximately 100% at Scunthorpe General Hospital.

**Vacancy rates**

Annual vacancy rates for medical staff in services for children and young people from February 2017 to January 2018 are shown below, at trust level and by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>0</td>
<td>20.7</td>
<td>10.2%</td>
</tr>
</tbody>
</table>
The trust had an annual vacancy rate of 10.9% for medical staff in services for children and young people, which was above the trust’s target vacancy rate of 6.3%. The target was not met at Scunthorpe General Hospital.

Please note, while the figures for January 2018 show all three sites meeting the trust’s vacancy target, the annual rate is calculated over the 12 month reporting period.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Annual turnover rates for medical staff in services for children and young people from February 2017 to January 2018 are shown below, at trust level and by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>1.0</td>
<td>8.6</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 18.2% for medical staff in services for children and young people, which was higher than the trust’s target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Sickness rates for medical staff in services for children and young people from January 2017 to December 2017 are shown below, at trust level and by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>132.0</td>
<td>3,162.4</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 3.0% for medical staff in services for children and young people, which was lower than the trust’s target of 4.1%.

**Bank and locum staff usage**

The trust did not provide the total medical shifts available. Therefore, bank and locum usage as a proportion of total shifts available cannot be calculated.

From February 2017 to January 2018, the trust reported the following shifts for bank and locum staff:

Scunthorpe General Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor in Training</td>
<td>425</td>
<td>228</td>
<td>90</td>
</tr>
</tbody>
</table>

In services for children and young people at Scunthorpe General Hospital, no medical staff shifts were covered by temporary staff over this period, and no shifts were left unfilled to cover staff...
absence, if doctor in training shifts are excluded.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

In December 2017, the proportion of consultant staff reported to be working in services for children and young people at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Staffing skill mix for the 45 whole time equivalent staff working in services for children and young people at Northern Lincolnshire and Goole NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Middle career</td>
<td>9%</td>
<td>%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</td>
<td>%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

The trust had an electronic observation system, accessed through electronic hand-held devices and laptops across hospital sites. The children’s service used a mixture of electronic and paper recording.

Throughout the service, we observed records were stored securely. Random checks on records trolleys confirmed they were locked when not in use.

We reviewed 13 children’s records. We saw evidence of multi-disciplinary team involvement in the child’s care, evidence of daily ward round including review with senior clinicians, diagnosis and management plans documented and whether a consultant saw the child within 12 hours of admission.

We found some gaps in one child’s records. One baby had received intravenous fluids however, checks of the fluids were not documented on the fluid chart hourly and the admission checklist had not been completed.

Medicines
We found medicines management was in line with trust policy, for example, medicines were stored in locked cupboards. Entry to the treatment rooms where drugs were stored was by key code entry. Staff we spoke with told us that trained staff held individual drug keys, which had a unique number on applicable to the individual. This meant that keys were traced back to individual nursing staff. To access the controlled drugs cupboard two staff were present, as the cupboard would only open if two staff keys were used.

We found intravenous potassium chloride fluids stored in the same cupboard as fluids without potassium chloride in the neonatal unit which was not in line with the trust’s policy. This was escalated to the nurse present at the time of the inspection.

Pharmacists visited the neonatal and children’s wards Monday to Friday or when required.

The clinical areas followed a controlled drug checking procedure. We checked the frequency of checks documented in the controlled drugs book and noted checks were carried out in line with the trust’s policy.

Daily monitoring of drug fridge temperatures had taken place. Drug fridge temperatures were documented and within the accepted temperature range.

Safer medication newsletters communicated guidance and feedback from incidents. The newsletter we reviewed (Issue 27 / January 2018) gave guidance on fridge temperatures, safe and secure storage, the outcome and changes following a serious incident and feedback on a trust wide omitted doses audit.

The trust scored 9.1 out of ten for question 36, ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts. This question was asked of parents and carers of children up to 15 years of age.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q36. Were you given enough information about how your child should use</td>
<td>15 adults</td>
<td>9.1</td>
<td>About the same as other</td>
</tr>
<tr>
<td>the medicine(s) (e.g. when to take it, or whether it should be taken with</td>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>food)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Incidents**

Systems were in place to ensure incidents were reported, investigated and lessons learnt.

Incidents and significant events were discussed at ward meetings and at governance meetings.

Medical and nursing staff we spoke with confirmed they knew how to report incidents and had received feedback from the incidents they reported. Staff we spoke with said that incident feedback was cascaded through staff meetings, in the communication book and by email. Staff we spoke with told us that safety alerts were circulated via email.

Morbidity and mortality meetings discussed the children’s and young people’s issues experienced across multi-disciplinary teams. Staff we spoke with told us of a surgical child in the emergency department. The situation was discussed through the mortality and morbidity meeting and leaning was identified. The learning in this case was the importance of using clinical judgement and not just using tools such as the paediatric early warning score.

**Never Events**
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events in services for children and young people.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in services for children and young people at Scunthorpe Hospital.

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

The safety thermometer is a local improvement tool for measuring, monitoring, and analysing patient harm, and harm free care. Staff we spoke with told us the safety thermometer was not used in children’s services.

We saw performance type information displayed on boards in clinical areas. On Disney ward, the four main headings on this display board were clinical leadership, patient experience, privacy, dignity and patient safety.

Is the service effective?

Evidence-based care and treatment

Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) guidance was used to inform care. We reviewed 11 evidence based guidelines, which were up to date. Staff we spoke with told us that policies, procedures and guidelines were discussed and agreed through governance meetings.

The neonatal unit had implemented the ‘Quiet Hour’. Research had confirmed babies need quiet and calm in their first weeks of life, especially preterm or fragile new-borns. To ensure minimal noise levels the neonatal unit had installed the electronic ear, which responded to noise levels in the immediate environment. Red was an indication that noise was present whilst green identified a quiet environment.

Staff we spoke with told us the neonatal unit was working towards implementation of the ‘Bliss Baby Charter’. The baby charter was a practical framework for neonatal units to self-assess the quality of family-centred care they deliver against a set of seven core principles. The neonatal unit had registered for Bliss and was due to submit the audit data.

Paediatric critical care meetings took place four monthly. We observed one meeting, which took place on the 11 May 2018. Some of the topics discussed included sepsis, PEWS update, training update equipment issues, children’s care reviews and guidelines. The guidelines included the operational policy for critical care patients, major trauma guidelines, sedation policy and management of children with complex needs.
Community nursing staff told us they had worked jointly with the adult tissue viability team to develop a paediatric tissue viability tool. The paediatric tool was in development and was at the stage of being agreed through the trust.

**Nutrition and hydration**

Parents were entitled to free meals when resident in one of the neonatal unit’s flats. Mothers ordered their meals from the menu each morning. The mothers we spoke with confirmed they could access food whilst on the neonatal unit. In addition, microwave, tea and coffee making facilities were also available.

A risk assessment for the storage of breast milk was completed; the next review was due on the 26 April 2021. The milk fringe was unlocked; breast milk bottles had tamper proof labels in place.

Mothers had access to a breast-feeding room, which was also used as a quiet room.

Staff made dietetic referrals when required. The dietitian was contactable by their bleep and usually visited the neonatal unit once a week.

A variety of food choices was available to children and young people. Special diets, for example diabetic, gluten free, renal, and textured and allergy diets were available. Specialised milk formulae were provided through pharmacy.

Basic foods were kept on the children’s wards, which could be provided outside of the main meal times.

**Pain relief**

The adult pain management team provided support and advice to staff on pain management issues when required.

Out-of-hours an anaesthetist was on call and structured pain relief was in place for each child.

Babies, children and young people had access to a range of pain distraction techniques and pain medication. If babies were unsettled or appeared to be in pain, staff discussed this with the doctor to determine whether pain relief was required.

We reviewed two children’s notes admitted for surgery and saw that children’s pain scores were recorded and escalated in line with trust guidance.

**Patient outcomes**

**Paediatric diabetes audit 2015/16**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48mmol/mol and 58mmol/mol (6.5% and 7.5%)”.

Scunthorpe General Hospital’s performance was less positive overall in 2015/16.

The crude proportion of patients receiving all key care processes annually was 68.8%, which made the hospital a positive outlier. The national aggregate was 35.5%. The hospital’s result for this metric in the 2014/15 report was 49.2%.
The mean average HbA1c value (adjusted by case-mix) for the hospital was 72.2 mmol/mol, which was worse than expected compared to the national aggregate of 68.3 mmol/mol. This was a deterioration from the hospital’s result in the 2014/15 report, when its performance was within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 69.0, which reflected clinically significant improvement when compared to the previous year’s median, which was 73.3.

(Source: National Paediatric Diabetes Audit 2015/16)

Following our inspection, the trust provided us with the results of the 2016/2017 paediatric diabetes audit, which showed an improving picture. The median HbA1c was 67, which showed a further improvement on the previous year.

**Emergency readmission rates within two days of discharge**

From September 2016 to August 2016, no specialty at the trust reported six or more readmissions following elective admission for patients either aged less than one year of age, or aged from one to 17 years old.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission over this period. Only those specialties where six or more readmissions recorded are shown in the table.

<table>
<thead>
<tr>
<th>Emergency readmissions within two days of discharge following emergency admission among the under one age group, by treatment specialty (September 2016 to August 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
</tr>
<tr>
<td>Readmission rate</td>
</tr>
<tr>
<td>Paediatrics</td>
</tr>
<tr>
<td>No other specialty at this trust had six or more readmissions.</td>
</tr>
</tbody>
</table>

For patients aged under one year old the trust performed better than the England average for emergency readmission rates following an emergency admission to general paediatrics. It should be noted that the number of readmissions at the trust was quite small.

<table>
<thead>
<tr>
<th>Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (September 2016 to August 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
</tr>
<tr>
<td>Readmission rate</td>
</tr>
<tr>
<td>Paediatrics</td>
</tr>
<tr>
<td>No other specialty at this trust had six or more readmissions.</td>
</tr>
</tbody>
</table>

For patients aged from one to 17 years of age the trust performed better than the England average for emergency readmission rates following an emergency admission to general paediatrics. It should be noted that the number of readmissions at the trust was quite small.
Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From October 2016 to September 2017 the trust performed similar to the England averages for the percentages of patients aged from one to 17 years of age who had multiple admissions for asthma and diabetes. The trust performed better than the England average for the percentage of patients in the same age group who had multiple admissions for epilepsy.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>14.5%</td>
<td>117</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>11.8%</td>
<td>51</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>0.0%</td>
<td>*</td>
</tr>
<tr>
<td>1 to 17</td>
<td>23.8%</td>
<td>42</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

National Neonatal Audit Programme

Both of the trust’s sites that provide services for children and young people participated in the 2017 National Neonatal Audit.

Scunthorpe General Hospital’s performance in the four measures in this audit relevant to services for children and young people was as follows:

**Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5ºc and 37.5ºc**

Out of 30 eligible cases identified for inclusion, 53.5% of babies less than 32 weeks gestation had a temperature taken within an hour of admission that was between 36.5ºc and 37.5ºc. This was within the expected range when compared to the national aggregate of 61.0%.

The hospital did not meet the audit’s recommended standard of 90% for this measure.

**Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission**

Out of 160 eligible cases identified for inclusion, 99.1% had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. This was
a positive outlier when compared to the national aggregate of 90.5%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

**Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity**

Out of the 27 eligible cases identified for inclusion, 96.1% of babies of very low birthweight or less than 32 weeks gestation received appropriate screening for retinopathy of prematurity. This was within the expected range compared to the national aggregate of 94.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

**Babies with gestation at birth <30 weeks who had received documented follow-up at two years gestationally corrected age**

Out of the seven eligible cases identified for inclusion, 42.9% of babies with a gestation at birth of less than 30 weeks received a documented follow-up at two years gestationally corrected age. This was in the bottom 25% of results. The national aggregate was 61.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

*(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)*

During our inspection, we asked the service leads about the actions they had taken following the results of the neonatal audit. They told us that they worked more closely with their obstetric colleagues and they worked closely with the neonatal network. There was better temperature monitoring of babies on the labour ward now. A clinical audit action plan was in place. We saw evidence in clinical governance meeting minutes of discussion around improving the retinopathy of prematurity outcome by the possible purchase of a retinal camera.

**Competent staff**

Neonatal staff we spoke with told us that ten staff appraisals were late. Appraisals were scheduled for completion in April 2018; however, unit activity and acuity levels had stopped them from taking place. A plan was now in place with new dates identified for completion of the staff appraisals.

**Appraisal rates**

From April 2017 to January 2018, 64.3% of staff within services for children and young people at the trust had received an appraisal compared to a trust target of 95%. The target was met for only two out of six staff types at trust level. Only half of qualified nurses had received an appraisal.

**Scunthorpe General Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>95.0%</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>24</td>
<td>35</td>
<td>68.6%</td>
<td>95.0%</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>32</td>
<td>59</td>
<td>54.2%</td>
<td>95.0%</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
The 95% target was not met across all staff groups at either hospital staff, or for staff in the cross-site safeguarding and looked after children team. At both hospital sites the target was not met for either qualified nursing staff or medical staff.

*Source: Routine Provider Information Request (RPIR) P43 Appraisals*

Following our inspection, we requested up-to-date appraisal figures, broken down by ward. However, most staff were still not meeting the trust target for completion of appraisals.

Preceptorship packages were in place for healthcare support workers.

Senior staff we spoke with told us staff completed competency assessments, for example, prior to caring for children on a continuous positive airway pressure (CPAP) machine. Staff who worked on the children’s high dependency unit had completed this training. The education nurse monitored staff training and competencies and where there was a training need for individual staff the education nurse ensured staff completed the appropriate training and were assessed against the relevant competencies. Senior staff said they were confident of staff competency levels. Staff we spoke with told us that most nursing staff who worked in the high dependency area on Disney
ward had completed their blood gas competencies. The paediatric education nurse had organised training sessions on sepsis. Staff we spoke with told us that an online sepsis-training module was being developed for paediatric, theatre, outpatients and emergency department staff.

Discussions with a senior theatre nurse identified they were not aware of any formal children’s skills competency documentation for completion by staff. Following the inspection, the trust provided details of a clinical skills for anaesthetics check list that staff were meant to complete, this wasn’t specific to paediatrics but covered certain paediatric elements including safe airway techniques.

At our previous inspection, we said the trust must ensure the number of staff who have received training in advanced paediatric life support is in line with national guidance and the trusts own target. The majority of band five and six nurses on Disney ward were advanced paediatric life support (APLS) trained. All except four newly qualified nurses had completed APLS training. Two of the staff we spoke with said two training sessions were offered annually, one on each hospital site to ensure nurses skills and competencies were maintained.

Neonatal staff had completed their neonatal life support (NLS) training. A neonatal life support (NLS) trainer was based on the neonatal unit where bi-monthly training simulations were attended by medical and nursing staff.

Staff we spoke with told us they had sufficient training for their needs and monthly multidisciplinary training sessions had taken place. In addition, skills training was available for staff to attend, one example staff gave was the clinical skills station (2017) completed with a specialist children’s critically ill transport team. We saw a list of 2018 skills training updates dates displayed in Disney wards education room. Examples of skill updates identified included tracheostomy updates and neurological assessment updates.

Senior staff we spoke with told us that radiology staff had completed a combined paediatric and adult resuscitation-training day. No paediatric trained nurses worked in the ophthalmic clinic and adult outpatient’s clinic; the staff we spoke with said they had not completed paediatric basic life support training.

Theatre staff confirmed that simulation training took place monthly, topics included, asthma, bronchiolitis, sepsis and cardiac conditions in babies. Staff we spoke with described these training sessions as well received.

Senior medical staff supported medical training. New medical staff attended deanery, trust and departmental inductions. Each new doctor had an allocated mentor. Medical staff had designated days and times for teaching and training.

Anaesthesia for children, whether local or general, was provided by an anaesthetist with specialist training and experience in paediatric anaesthesia.

**Multidisciplinary working**

The multi-disciplinary team provided clinical assessment and treatments using a child friendly approach, which utilised play and distraction therapies.

Play specialists worked alongside the multidisciplinary team to support children and young people

Staff identified effective working relationships between children and adolescent mental health service (CAMHS) professionals and paediatricians. Staff we spoke with said CAMHS had provided 1:1 patient support when necessary.
Discharge planning for the baby, child or young person involved the members of the multidisciplinary team involved in their care, for example, nurses, community teams, continuing care team, GP, social care professionals and therapists.

Staff shared information with health visitors and social work staff to update them and involve them in discharge planning processes of new mothers who had experienced mental health issues.

A consultant from a tertiary centre attended weekly paediatric radiology multi-disciplinary team meetings.

Multi-disciplinary team attendance took place at the theatres advisory group and children’s surgical group for children.

In our previous report we said the trust should take steps to ensure appropriate transition pathways were in place for young people moving into adult services. At this inspection, we identified well-established transition programmes in place for young people between the ages of 16 years and 18-19 years. Transition programmes supported young people living with epilepsy, diabetes, cystic fibrosis and attention deficit hyperactivity disorder.

The trust identified the transition arrangements in place for young people with cerebral palsy or other neurological conditions at the age of 16 years. The rehabilitation medicine doctor undertook the initial assessments on young people who remained under joint care with the paediatric service and rehabilitation medicine service. Paediatric services or the learning disability team continued to input into the young person’s therapy needs until the young person reached 18 or 19 years of age.

The complex care team managed young people in transition to adult services. In North Lincolnshire, complex care matrons worked closely with children’s acute services. At the beginning of each transition the team, children’s acute services and the patient’s family worked closely together. This enabled families to develop a close working relationship and trust with the complex care matron responsible for the young person. Once a working relationship was established, the transition from one service to another was completed and the complex care team took sole responsibility for the young person.

Neonatal staff said they had close links with the children’s community team and community physiotherapy teams for those babies who required ongoing support at home.

The neonatal service was part of the ‘Yorkshire and Humber Neonatal Network’.

The multi-disciplinary team were made aware of a baby, which was part of a multiple pregnancy through the presence of a butterfly logo on the baby’s cot or incubator. In this instance, the presence of this butterfly logo told people that sadly not all babies had survived.

CQC Children and Young People’s Survey 2016 – Q36

In the CQC Children and Young People’s Survey 2016 the trust scored 8.6 out of ten for question 23, ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.
(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Seven-day services**

The service could access on call pharmacy support and pharmacy during specified times at the weekend.

Staff we spoke with told us that CAMHS support was available throughout the week and after 5pm.
Radiology services were provided 24 hours a day, seven days a week including in-hours and overnight on call.

A children’s community team provided on-call support at weekends to the ward staff should a child be discharged home requiring community nurse support.

Twenty-four hour paediatric, anaesthetic and neonatal consultant support was in place.

Staff could access physiotherapy on-call when required.

**Health Promotion**

Primary health leaflets were displayed throughout the children’s service. These leaflets included advice in areas such as dental care, dental erosion, the BCG vaccination and your baby.

The ‘Lullaby’ trust poster ‘The ABCs of Safer Sleep’ was displayed in the assessment unit and neonatal unit. The poster’s included advice to parents.

Health promotion and advice guidance was available in the neonatal unit. For example, The United Nations Children’s Fund (UNICEF) feeding cues were displayed for responsive feeding, demand feeding and nasogastric feeding.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Staff we spoke with demonstrated through discussion that they understood the consent process. Paediatric and neonatal staff said that the majority of time parents gave verbal consent; however, on occasion written consent would be requested. Staff identified examples of when written consent was obtained which included prior to surgery and immunisations. We reviewed children’s and babies notes for evidence of consent processes and saw completed consent forms for specific investigations, for example, prior to surgery.

We asked staff about their understanding regarding the Fraser guidelines and Gillick competency in relation to consent processes for children and young people. The staff we spoke with demonstrated understanding of this guidance and how they implemented it in practice.

**Other CQC Survey Data**

**CQC Children and Young People’s Survey 2016 Data**

The trust performed about the same as other trusts for five of the six questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. For the one remaining question, the trust did not receive a score:

**CQC Children’s Survey questions, effective domain, Northern Lincolnshire and Goole NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q21. Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults*</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Is the service caring?

Compassionate care

Throughout our inspection, we observed members of medical and nursing staff providing compassionate and sensitive care that met the needs of babies, children, young people and their parents. Staff had a positive and friendly approach and explained what they were doing, for example when preparing children for theatre.

We spoke with three young people and 10 parents who told us they were happy with the care and support they received.

To maintain dignity the neonatal unit used mobile screens when mothers breast-fed their babies.

Feedback cards and comment boxes for parents to use were available throughout the service. We saw positive feedback about their experiences given by parents on cards displayed throughout the service.

The patient experience poster displayed in the assessment unit confirmed the outcome of the friends and family test (March 2017 to 2018). The results confirmed that 94.9% of people would recommend the children’s service to friends and family. Friends and family test feedback from 1 January 2018 to 31 January 2018 on Disney ward confirmed that 100% recommended the service.

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for all 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016:

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults*</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
<td>EMU</td>
<td>Comparison</td>
</tr>
<tr>
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</tr>
<tr>
<td>Q42. Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q58. Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 children**</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q64. If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 children</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q74. Do you feel that the people looking after you were friendly?</td>
<td>8-15 children</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q75. Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 children</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-7 adults = asked of parents and carers of children up to seven years of age.
**8-15 children = asked of children aged from eight to 15 years of age
(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

Bereavement support was available for parents and siblings of children and young people who had passed away. Families could access information on support services, for example, sibling support services. Staff we spoke with told us that copies of the baby’s hand and foot print were taken and given to the parents as part of a bereavement package. An on-site memorial garden was available for parents and their families to use.

Parents and families accessed spiritual support through the multi-faith service provided by the chaplaincy within the hospital. Chapel and multi-faith facilities were available for families to access.

Parents and young people described staff as child friendly, approachable and welcoming. The three young people we spoke with said staff had met their needs and had ensured their confidentiality. They also told us that they would recommend the service to others.

Needs of new young mothers were re-evaluated regularly, demonstrating that appropriate emotional support was available for both mother and baby. For those mothers who experienced mental health problems or learning disabilities they received additional emotional support through the multi-disciplinary team. Health visitors and social workers would be involved in their care and to ensure enough support was in place discharge planning for home would commence on admission to the neonatal unit.

Parents staying with a sick child overnight received free parking.

Parents accessed emotional support through the ‘Prem Group’, which was a neonatal support group. Informal sessions took place at a local children’s centre where parents could access support, advice and play for their pre-term babies on alternate Mondays.

Staff we spoke with said parents were not invited to attend recovery to help support their child’s emotional needs. Once recovered, the child was returned to the ward by staff that were not always known to them.

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for all five questions relating to emotional support.
support in the CQC Children and Young People’s Survey 2016:

CQC Children and Young People’s Survey 2016 questions, emotional support, Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults*</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q65. Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children*</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q67. If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 children</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-7 adults = asked of parents and carers of children up to seven years of age.
**8-15 children = asked of children aged from eight to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

We spoke with 10 parents and three young people about their experiences. Five of the parents mentioned specifically they were involved in care and decision-making processes. Parents we spoke with said staff had spoken with them and reviewed their child’s care needs daily. The young people we spoke with said they had been involved in and had agreed their care plans and pathways.

On the neonatal unit we observed staff interactions with parents, individually and as part of ward rounds. We saw that staff were respectful and attentive to the parents and babies needs and explained what they were doing prior to carrying out any actions. Two neonatal outreach nurses were available for parents to contact.

Parents in the neonatal unit could attend parent craft sessions to ensure they had the skills to care for their baby. These sessions included, giving medication, feeding advice, nappy care, bathing and making up feeds. Parents were also offered resuscitation and choking training before discharge.

A selection of guidance was available for mothers and fathers in the neonatal unit. The information included the benefits of Kangaroo care skin-to-skin contacts for mother and baby and Bliss – comfort-holding guidance.

On the neonatal unit and Disney ward, information boards identified the name of the young person’s nurse caring for them. Photo galleries displayed identified staff.

Throughout Disney ward, we observed information presented pictorially and in written form. For example, the information, which described autism and children with immune system problems, was written simply and displayed on the ward corridor walls.
We saw information displayed in the clinical areas, which showed that patients and their families were consulted about their experiences and how things had improved. On Disney ward, we saw feedback from ‘you said, we did’. For example; you said, ‘The parent's beds are uncomfortable to sleep on’, we did, ‘We have replaced our uncomfortable fold out beds with recliner chairs for parents who wish to stay overnight with their children’.

CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for two questions, and about the same as other trusts for 18 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. The trust received no score for the one remaining question.

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q11. Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults*</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>6.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q13. Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>0-15 adults</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>7.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q59. Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 children*</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q60. When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 children</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Age group</td>
<td>Trust score</td>
<td>Comparison to other trusts</td>
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<tr>
<td>Q61. Did you feel able to ask staff questions?</td>
<td>8-15 children</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q62. Did the hospital staff answer your questions?</td>
<td>8-15 children</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q63. Were you involved in decisions about your care and treatment?</td>
<td>8-15 children</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q66. If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 children</td>
<td>No Score</td>
<td>-</td>
</tr>
<tr>
<td>Q69. Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 children</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q70. Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 children</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q72. When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 children</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-15 adults = asked of parents and carers of children up to 15 years of age.
**8-15 children = asked of children aged from eight to 15 years of age
(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

Adolescents from the age of 12 years were cared for in a single sex, three bed bay area on Disney ward at Scunthorpe General Hospital. Staff we spoke with told us that when a mix of boys and girls were admitted they would separate them by nursing them in the cubicles as well as the bay. This meant that privacy and dignity needs of each patient group were maintained.

Indoor and outside play areas were available for children and young people to use on Disney ward. A pool table was situated in the outdoor play area for use by young people.

We saw facilities for parents and carers throughout the paediatric and neonatal services, for example, bedrooms, kitchen facilities, bathing facilities. The neonatal unit contained two flats, which were both suitable for disabled use. Priority was given to parents with extremely sick babies, who were breastfeeding, or whose babies were awaiting discharge. There was a double bed in each flat so partners could stay, and an extra bed could be provided if siblings stayed.

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for 14 of the 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016. For the remaining three questions the trust did not receive a score.

CQC Children and Young People’s Survey 2016 questions, responsive domain, Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults*</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Age group</td>
<td>Trust score</td>
<td>Comparison to other trusts</td>
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</tr>
<tr>
<td>Q5. Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q55. Was the ward suitable for someone of your age?</td>
<td>12-15 children**</td>
<td>No Score</td>
<td>-</td>
</tr>
<tr>
<td>Q8. Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q37. Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q56. Were there enough things for you to do in the hospital?</td>
<td>8-15 children</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q57. Did you like the hospital food?</td>
<td>8-15 children</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q71. Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 children</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q73. Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 children</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q2. Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>-</td>
</tr>
<tr>
<td>Q3. Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>-</td>
</tr>
</tbody>
</table>

*0-15 adults = asked of parents and carers of children up to 15 years of age.
**12-15 children = asked of children aged from 12 to 15 years of age
(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Meeting people’s individual needs**

An external provider provided children’s and adolescent mental health services (CAMHS). The service was not on site 24 hours a day, however, a system of ‘on-call’ operated for children and young people who required assessment and intervention out of hours. CAMHS service responsibilities included the provision and monitoring of pathways used within the trust. This
guidance was available for staff within children’s services via the trust intranet. A clear pathway existed for contacting the service out of hours.

Telephone access with a CAMHS practitioner Monday to Friday was available to capture children and young people admitted overnight for medical reasons who required CAMHS assessment. The trust identified this was carried out on the same day of the referral or once the young person was declared medically fit.

In the last 12 months, no children or young people were admitted to Disney ward with CAMHS needs.

Staff we spoke with told us they ensured that children with special needs had their needs met through the development of a plan in liaison with the child and parents. We saw three complex needs children’s care plans and noted that children’s specific needs including care requirements were noted. Staff we spoke with told us that a complex needs nurse supported children and young people with complex needs.

Staff we spoke with could access interpreters to ensure parents were kept informed and able to ask questions relating to their child’s care and treatment options.

We saw information leaflets were available for parents and carers in different languages.

**Access and flow**

Agreed pathways of care supported the children’s services operational policies and agreed guidelines were available on the trust intranet.

Staff we spoke with told us that children and young people who required open access to the ward or were frequent attenders could access the service. Children’s medical records were held in the medical records department; however, complex needs children’s care plans were kept on the ward.

A children’s generic community team provided a seven-day service from 8am to 6pm. The team was led by a band six nurse who was supported by specialist children’s nurses in areas such as respiratory, complex needs and oncology. The team told us that joint working and liaison had taken place with tertiary centres. A new rheumatology service had been developed and the team had worked closely with a tertiary centre to ensure the same feeding guidance was followed.

Staff we spoke with said a pre-assessment service was available for children and their parents to attend prior to undergoing surgery.

Children admitted for surgery were placed on theatre lists mixed with adult patients. However, staff said children’s theatre cases were always at the beginning of theatre lists. Staff we spoke with told us that approximately ten operations on children and young people took place weekly at Scunthorpe General Hospital. Children two years and under were referred to surgery specialist centre for surgery.

The NHS Constitution (2010) gives patients the right to access services within maximum waiting times. The standard is that at least 92% of people should spend less than 18 weeks waiting for treatment. Data provided by the trust showed that paediatrics were consistently meeting this standard between November 2017 and April 2018.

**Neonatal Critical Care Bed Occupancy**

From February 2017 to January 2018, the trust’s neonatal bed occupancy rate fluctuated from
45.5% (April 2017) to 92.0% in June 2017.

The trust’s neonatal bed occupancy rate was higher than the England average in eight of these 12 months. From August 2017 to January 2018, there was deterioration in bed occupancy. In February the trust’s bed occupancy was 77.3% compared to the England average of 69.0%.

**Neonatal bed occupancy rate from March 2017 to February 2018 at Northern Lincolnshire and Goole NHS Foundation Trust**

![Graph showing neonatal bed occupancy rates](image)

Note that data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

**Learning from complaints and concerns**

The women and children’s directorate aim was to resolve concerns and complaints at ward or departmental level. Action plans from a complaint were discussed at forums such as local governance meetings and lessons learnt meetings.

We asked Disney ward staff if they could tell us of any learning from complaints received. One example related to the labelling of all equipment to confirm cleaning had taken place.

Staff from the neonatal unit described a complaint around communication. The complaint was discussed at the team meeting; the learning was to encourage better communication.

Clinical areas displayed information to guide parents on how to make comments and complaints. How to give us your feedback leaflets were available to take away and Patient Advise Liaison Service (PALS) information, which included phone contact and email details were displayed in poster format.

**Summary of complaints**

From 7 February 2017 to 7 February 2018 there was one complaint about services for children and young people at Scunthorpe Hospital. The complaint related to delayed diagnosis.

The trust has three targets for closing complaints. The trust has a target to close complaints within 30 working days and a further target of 45 working days.

The trust has a target to close more complex complaints within 60 working days.

The above complaint had been open for less than 30 working days at the time of data extraction; therefore, we are unable to comment on performance at this stage.

*(Source: Routine Provider Information Request (RPIR) P61 Complaints)*
Is the service well-led?

Leadership

The children’s service formed part of the women’s and children’s group. The leadership team consisted of an associate chief operating officer, a clinical lead for each site and an interim chief nurse. The women’s and children’s group had a divisional clinical director and a general manager.

In each of the clinical areas we visited, we observed photographs of the women’s and children’s senior management team displayed. None of the staff we spoke with said they had met with the executive team. Staff told us that the chief executive officer was putting together some ‘meet and greet’ sessions.

Staff we spoke with said senior managers were visible and approachable. They said the matron came onto the ward daily; the divisional general manager had also visited the ward.

Staff we spoke with said they felt supported by band seven nursing staff on the ward. The trust identified they had developed a specific leadership course for ward managers and matrons to enhance and support the development of clinical leaders. Band six staff we spoke with said they could access leadership courses.

Vision and strategy

The women’s and children’s division strategy identified five objectives (2017-2020). A selection of these objectives included references to staffing, use of locums, improvement of paediatric community provision and the reduction of waiting times across outpatient, inpatient and community services. We noted that some of these objectives related to areas of risk identified on the children’s services risk register.

We saw the children’s services strategy displayed in the children’s areas and the neonatal unit. Staff we spoke with told us they had not been involved in its development and that the strategy was shared with the service the week prior to the inspection. The children’s services strategy encompassed all of children’s services, inpatient, community and specialist children’s services.

Vision statements were displayed in both Disney ward and the neonatal unit. We asked a staff member in the neonatal unit what involvement they had in the development of the vision statement. This person had not been involved with its development but was aware that the band seven nursing staff had been.

Culture

Staff we spoke with described good teamwork and a supportive culture between medical and nursing staff.

Staff were aware they could access support through the trust’s freedom to speak up guardian as well as through the trust staff advisory helpline.

Staff we spoke with were aware of the duty of candour and we saw additional guidance displayed which identified the ‘do’s and don’ts of an apology’ and the duty of candour process.

Students we spoke with described a supportive culture throughout the children’s, young people and neonatal services. Students said the nursing and medical staff worked together to provide care and decide the best options for the child.
Staff we spoke with told us that ward meetings took place regularly where they were encouraged to take an active part.

**Governance**

The children’s services governance structure showed a clear pathway from board to ward.

Monthly paediatric governance meetings took place. Some of the junior nursing staff we spoke with said they had not attended specific governance meetings. However, discussions with these staff confirmed they had some knowledge of the areas discussed through the governance forum and that they had received feedback from governance meetings. Staff we spoke with said they had received this feedback in the form of emails, by reading the ward communication folder and at team meetings.

Trust forums were in place (paediatric, neonatal forum, paediatric and emergency department forum and safeguarding forums) which provided opportunity for face to face joint working and assurance that treatment and care for children and young people was appropriate. Staff told us these forums reviewed and discussed policies, National Institute for Health and Care Excellence (NICE) guidelines and audit.

**Management of risk, issues and performance**

At our last inspection we recommended risk assessments were completed pertaining to the risks posed by the ward environment to those children and young people with mental health needs. Staff we spoke with told us the environmental risk assessment had not been completed at Scunthorpe Hospital. We also saw this risk identified on the division risk register.

Staff we spoke with said that the outcomes of audits such as documentation, paediatric early warning score and high dependency audits were fed back to them through the paediatric education nurse.

We saw and staff told us of the ‘lesson of the week’ where changes to practice were identified and communicated. The latest lesson of the week related to the resuscitation tagging system, where numbered tags were introduced and were checked weekly. However, when we checked the resuscitation equipment the tags were not numbered.

The women’s and children’s services group risk management strategy (DCP163, version 5.3) was a comprehensive strategy which identified leadership, accountabilities’ and responsibilities within the service. The strategy clearly defined individual roles and objectives within the service from staff who worked on the ward to the executive team. One of the risk strategy objectives was to continuously improve quality, safety and the patient experience. Part of the service’s associate chief nurse’s accountability included a clinical risk co-ordinator role. This meant they assured the board that processes and practices were in place, which kept all patients in the service safe.

Children’s services had an identified risk register in place, which identified actions, timescales and accountabilities. Monthly reviews of the risk register took place through governance groups. The trust identified monitoring of risks on the risk register was an ongoing process and which included quarterly reviews undertaken by the trust’s risk register confirm and challenge group.

The risk register identified 12 risks to the service. Staff identified six of these risks during the inspection. Two risks had a high rating. One of these high risks related to paediatric consultants having not received pathology results. Actions were identified to mitigate this risk. The second highest risk related to ‘both paediatric wards have reduced senior nursing cover on night shifts and at weekends due to a lack of band 6 nursing establishment in these areas’. Actions were identified
to mitigate this risk. Discussions with staff confirmed there had been no incidents reported where senior staffing levels were considered unsafe.

Nine risks were rated as moderate risks and one risk was a low risk. We saw from the actions taken to-date that progress had been made in reducing the risks.

Patient safety alerts were sent via all staff email to develop staff awareness and to ensure immediate action.

**Information management**

A divisional performance report was produced monthly, which allowed leaders to monitor performance and quality. The performance report presented key quality performance figures, such as number of never events, number of infections, staffing and waiting times.

Staff had access to clinical policies and guidelines on the trust intranet.

**Engagement**

News@NLaG was the trust joint staff and members newsletter, which identified the latest news, developments and staff achievements from around the Trust.

Paediatric staff we spoke with told us they attended staff meetings, which they found useful.

Parents could access and complete evaluation of care forms as a way to feedback experiences in hospital.

Parents and young people had given feedback of their experiences throughout the service. The ‘Family and Friends Test (FTT)’ was one area where feedback was received. Parents and young people had also provided feedback through thank-you cards and via ‘Tops’ feedback. Individual ‘Tops’ feedback was written on a card shaped as a top. All the feedback we saw was very positive.

**Learning, continuous improvement and innovation**

Children’s services had made improvements since the last inspection. There had also been some changes made following a recent clinical commissioning group (CCG) visit and neonatal peer review. Service leads were aware of further improvements that were needed.

The service had recognised the benefit of the advanced nurse practitioner role in providing support to staff.

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### End of life care

**Facts and data about this service**

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

The End of Life Team at Northern Lincolnshire and Goole NHS Foundation Trust consists of an end of life (EOL) clinical coordinator for the acute trust, an EOL lead nurse in the community and an EOL clinical practice educator. They work closely with clinical staff caring for patients with non-complex palliative needs and provide education.
In North Lincolnshire there are also specialist palliative care teams (SPCT) in both Scunthorpe General Hospital (SGH) and community led by a consultant in palliative medicine. In North East Lincolnshire an independent health organisation provides in reach specialist palliative care at Diana Princess of Wales Hospital (DPoW) and North East Lincolnshire community.

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

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

(Source: Routine Provider Information Request (RPIR) AC1 – Acute Context / Hospital Episode Statistics)

Is the service safe?

Mandatory training

Overall mandatory training rates

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses February 2017 to January 2018 for medical and dental staff and nursing staff is shown below:

Trust level Medical and dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Although the trust only met the target in three of the ten courses, there is only one medical staff eligible for the training so the completion rates are either 100% or 0%.

Trust level nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust achieved the target in four of the ten courses and has completion rates above 80% for five of the remaining six courses.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The service provided mandatory training in end of life care to all registered nurses and care staff. The study day included an explanation of the trust strategy, the five priorities of care for the dying person, documentation including assessments, mental capacity, nutrition and hydration, advanced care planning, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), fast tracking, symptom management and trust processes. The end of life clinical co-ordinator facilitated the training and monitored compliance rates.

The trust target for training was 85%. The end of life strategy group meeting minutes in April 2018, showed the nurse training compliance rate for pain and symptom control was 75%, care planning compliance was 73% and syringe driver training was 66%.

The training programme has been adapted to include communications skills. There were plans to extend the training to include patients identified with dementia, a learning disability or autism.

The end of life study day was available for medical staff; however, this was not mandatory at the time of our inspection.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for mandatory courses February 2017 to January 2018 for medical and dental staff and nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust achieved 100% completion in each of the safeguarding modules that the medical staff member was eligible for.
There was one palliative care consultant employed to provide care for end of life patients and support other medical staff in the trust.

Trust level nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust achieved the target in only one of the three safeguarding modules the nursing staff was eligible for. The other two modules had completion rates of 82%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding policies and procedures were accessible to staff via the trust’s intranet. Staff we spoke with understood how to identify and report safeguarding concerns including who to contact.

Cleanliness, infection control and hygiene

All ward areas, where end of life patients were being cared for, were visibly clean. We observed staff adhering to ‘arms bare below the elbows’ guidance and washing hands prior to patient contact.

There was wall mounted hand washing solutions at clinical sinks with handwashing instructions.

Infection control was included in mandatory training.

We observed personal protective equipment available for use in the mortuary. The mortuary environment was visibly clean. However; a trolley in use was dusty and required cleaning. Staff told us it had been stored until prior to the inspection because an alternative trolley required maintenance work. We observed this trolley, awaiting collection: this was also dusty.

There were cleaning schedules in place indicating daily, monthly and quarterly cleaning of the environment and fridges but not for other equipment. The trusts ‘mortuary cleaning and disinfection instructions’ included a section that provided guidance on cleaning equipment, however; this referred to autopsy room wash down procedures that were not carried out at this hospital.

In the public viewing area of the mortuary there were covers that, we were told, would be washed by a staff member rather than the hospital laundry service.

There was no separate dedicated area for storage of bodies with known infections, either from the wards or in the community. Staff tried to store bodies with infections either in the bottom of a cabinet or together and mark the cabinets with hazard tape to alert visitors. Porters were aware when transporting a deceased patient as body bags were used to easily identify them.
Some bodies needed storing for attention of the coroner; there were dedicated units that included clear instructions for staff to follow regarding managing the body.

**Environment and equipment**

There was no dedicated palliative care ward. Patients, in the hospital, deemed to be in the last days of life were nursed on general wards and identified by a discreet symbol on the trusts electronic patient boards. The end of life clinical co-ordinator and palliative care nurses monitored the location of patients daily.

The co-ordinator had identified that there was no flagging system to indicate when an end of life patient was approaching the last days of life. This meant that support would be able to be provided earlier.

We observed posters on wards to support staff in caring for end of life patients.

Syringe drivers, for administration of end of life medicines, were stored centrally in an equipment library. Of those we sampled, all had been maintained within the last 12 months. Data provided by the trust showed that there was a process for recording the maintenance of syringe drivers and these had been serviced within the 12 months prior to inspection.

The mortuary was a body store with 10 fridges, each with three compartments, two of which were allocated for coroner cases. There were also two bariatric storage areas (for large patients) and a freezer with three compartments. There was also an additional temporary refrigerated unit which had 12 compartments. This unit had been sourced to support winter pressures in the hospital, although this was not in use at the time of inspection.

Temperatures of fridges were monitored daily, however; ranges were not recorded. The probes were linked to an external system so that if the alarm sounded when the mortuary was not staffed, such as overnight, the hospital switchboard were alerted and they would contact the on-call staff to investigate. At the time of inspection, there was a maintenance issue with the freezer. An external probe was in use, however; this was not connected to the external system. This meant there was a risk that the alarm would not be heard or attended to.

We returned to the mortuary, the following week to see if the maintenance work had been completed on the freezer. We were told an external company had been authorised to carry out the repairs. This was expected to involve half of the units being taken out of use while they were repaired followed by the other half. We were told that there were hoping to extend the rental of the additional temporary units or source alternatives from the company providing the repair work.

**Assessing and responding to patient risk**

Assessments were carried out for end of life patients as part of their care in the last days of life. This included anticipatory medicines, physical comfort, psychological needs, spiritual needs, nutrition and hydration and wishes of the patient and those close to them. This documentation was available to be completed by all hospital clinical staff including doctors and nurses.

The trust used a national early warning score system (NEWS) when monitoring patients. NEWS is a system to allow early recognition of physical deterioration by close monitoring of vital signs of patients receiving hospital care. For patients identified as in the last days of life, we were told that the frequency of NEWS monitoring was either reduced or stopped depending on individual patient need.
The specialist palliative care nurses and the palliative consultant told us they reviewed patients, in the last days of care daily, during weekdays. The consultant told us that if they were concerned about a patient they would contact the ward at the weekend.

Patient safety notifications are issued to the NHS through the central alerting system (CAS). This is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS as well as others, including independent providers of health and social care. We reviewed minutes of meetings for the end of life strategy group and saw that CAS alerts were shared and discussed with staff if needed.

**Nurse staffing**

**Overall staffing rates**

The trust reported their staffing numbers below for January 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>5</td>
<td>4.22</td>
</tr>
<tr>
<td>Trust wide</td>
<td>6.47</td>
<td>7.41</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The trust employed an end of life clinical co-ordinator who was based at Scunthorpe General Hospital. However; the week prior to the inspection, the clinical practice educator at Diana Princess of Wales left the organisation and the co-ordinator was also offering support for both hospitals.

The palliative care team included three members of staff who supported the ward staff, both nursing and medical, with symptom management and control for end of life patients who were following a specific trust wide pathway for the last days of life.

**Vacancy rates**

From February 2017 and January 2018, the trust reported a vacancy rate of 7% in end of life care. This was worse than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From February 2017 to January 2018, the trust reported a turnover rate of 12% in end of life care. This is worse than the trust turnover target of 9.4%.

- Diana Princess of Wales Hospital: 0%
- Scunthorpe General Hospital: 29%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From January 2017 to December 2017, the trust reported a sickness rate of 2% in end of life care.
at Scunthorpe General Hospital.

This was better than the trust target sickness rate of 4.1%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

The trust did not report any bank or agency usage for end of life care.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

The trust has reported their staffing numbers below for January 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>1</td>
<td>0.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From February 2017 and January 2018, Scunthorpe General Hospital reported a vacancy rate of 20% in end of life care. This was worse than the trust target of 6.28%. The figure is high due to the small number of WTE expected in end of life care.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

There was one consultant for palliative care employed at the trust. This meant that there was a risk of no specialist cover for leave or sickness despite limited support available from the local hospice. Commissioning Guidance for Specialist Palliative Care (2012) recommends the minimum requirement for a population of 250,000 people is two whole time equivalent palliative care consultants, or one per 250 bed hospital. The consultant covered two acute hospitals and community patients. The vacancy was also identified following the last inspection. The end of life strategy group was aware of the vacancy, however; no recruitment had taken place.

Turnover rates

From February 2017 to January 2018, the trust reported a turnover rate of 0% in end of life care.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

The trust has not provided any data for sickness for medical staff in end of life care.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

The trust did not report any bank or locum usage for end of life care.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)
Records

Paper records for end of life patients were stored securely in locked trolleys located near nurse’s stations.

Patients in the last days of their life were identified by a discreet symbol on the wards electronic boards. This could be accessed by the end of life clinical co-ordinator and specialist palliative care team remotely to locate patients.

The trusts documentation for end of life patients in the last days of life was widely available on all wards visited. This had been implemented since the last inspection. The document consisted of two parts, part one included details of patients, those close to them and health professionals involved in the care. The document was designed for all staff to complete with sections for allied health professionals as well as doctors and nurses. Guidelines for symptom management were also included in addition to assessment and review sections. Part two included care plans dependent on individual symptoms.

At our last inspection, the end of life document was in place for 8% of all deaths. The March 2018 quality and safety committee records showed this had improved and the documentation was now used for 25% of patients.

We reviewed the ‘last days of life’ document for two patients. They both showed discussions with patients and those close to them and also future plans that were in place. Both included information about anticipatory medicines.

Medicines

The trust had policies and procedures in place for the management of medicines including anticipatory drug prescribing for end of life care for patients receiving end of life care. Anticipatory medicines are medicines that are pre-prepared and kept with the patient for administration by a doctor or nurse. They are medicines that can help with symptom control in the last days of life.

Anticipatory medicines were ordered and stored in the hospital, securely, until the patient was discharged. However current processes still required the G.P to prescribe the medicines prior to administration. This could result in a delay to the medicines being administered. The trust’s end of life steering group was in the process of changing the process so that the medicines would be prescribed prior to the patient’s discharge helping to prevent any delays to administration.

We reviewed two records for anticipatory medicines and found that all medicines had been prescribed appropriately.

Doctors we spoke with told us that they would contact the palliative care team for advice and guidance if needed.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events
within end of life care.

Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from March 2017 to February 2018.

Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

Following the inspection, the trust reported one serious incident, in January 2018, coded as end of life that included immediate actions taken for a grade three pressure sore.

Staff reported incidents through the trusts electronic system and were confident to report. We were provided verbal examples of incidents, however; no feedback had been received and there was no shared learning.

Meeting minutes for the trusts end of life strategy group included details of a patient who was discharged with a possibility that the patient may die during the journey; the patient did die in the ambulance. There was no policy for patients dying in transit: the patient was returned to the hospital. The incident was not reported as an incident on the trusts system.

Staff we spoke with understood the term duty of candour and understood how to apply the principles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person.

Is the service effective?

Evidence-based care and treatment
Care and treatment, we observed was in line with national guidance such as the National Institute for Health and Care Excellence (NICE) (NICE) NG31: care of dying adults in the last days of life and ambitions for palliative and end of life care: a national framework for local action 2015-2020.

Each ward had a folder that contained information and guidance for staff with regards to caring for end of life patients. All wards we visited were able to locate the information quickly. We found the policies for anticipatory drugs* and pain and symptom management in last days of life had a review date of December 2017, this meant that staff might be accessing out of date information. There were updated current versions available on the trust intranet

Nutrition and hydration
We spoke with nursing and medical staff about the needs of patients in the last days of life. All staff we spoke with told us that each patient was cared for individually. This meant that depending on the condition of the patient, oral diet and fluids may be taken or fluids may be given intravenously, if a cannula was in situ or subcutaneously (under the skin).

Pain relief
Staff assessed pain scores as included in the last days of life care documentation.

We reviewed two anticipatory prescription records for end of life patients and saw that pain medicines had been prescribed appropriately.
Anticipatory medicines included pain relief that remained with the patient if discharged from the hospital.

Leaflets given to patients included opioids in palliative care.

Patient outcomes

End of life care Audit: Dying in Hospital
The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed marginally worse than the England average for one of the six clinical indicators, they scored worse than the England average for three indicators, the same for one and better than the England average for one.

For proportion of patients for whom there was documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days, the trust scored 82% compared to the England average of 83%.

For proportion of patients for whom there was documented evidence within the last episode of care that health professional recognition that the patients would probably die in the coming hours or days had been discussed with a nominated person important to the patient, the trust scored 79% which is the same as the England average.

The trust did score better than the England average for the proportion of patients for whom there was documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care, where they scored 83% compared to 66% England average.

The trust answered yes to seven of the eight organisational indicators, only answering no to “Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?”

(Source: Royal College of Physicians)

A records audit was carried out by the trust in November 2017 and aimed to assess the adherence to resuscitation council guidelines in identifying deteriorating patients. Data collected included the DNACPR compliance. The audit found that, at this hospital, one out of 11 patients had an incomplete form; and two had incomplete documentation. Four of the forms did not include if there had been an assessment of mental capacity and there was no best interest decision documented for three patients.

Audits of the ‘care in the last days of life’ documentation were carried out in November 2016 and December 2017. The first audit results provided limited assurance, however; the re-audit provided moderate assurance. For eight standards that were comparable to the ‘National End of Life Care Audit – dying in hospital’ (2015), there were improvements for all of these.

The SPCT supported staff, particularly doctors as well as patients and those close to them. As the team only worked Monday to Friday between 9am and 5pm, the end of life clinical coordinator told us that an audit of patients admitted on a Friday was in progress at the time of inspection.

Competent staff

Appraisal rates
From April 2017 to January 2018, 71% of qualified nursing and health visiting staff within end of life care at the trust had received an appraisal compared to a trust target of 95%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Following the inspection, the trust provided information which indicated that the appraisal rate for the specialist palliative care team and for the end of life clinical co-ordinator had improved and was 100%.

End of life training, either face to face or e-learning was mandatory for all nursing staff. Medical staff could access the training but it was not mandatory. The palliative care nurses were involved in the delivery of training, including facilitating competency framework requirements for syringe drivers.

Since the last inspection, link nurses for end of life care had been established on all wards. Many of the wards had one representative, although some wards included a registered nurse and a health care assistant. We found that staff on the wards were aware of their link nurse. However; the link nurses were not always available if there was only one for that ward.

The role of the link nurse included attending trust wide end of life meetings, cascading any updates in guidance or process, identifying any concerns and support for other staff. We found that they were very passionate about providing excellent end of life care.

Staff we spoke with felt supported with their development needs. For example, a ward nurse had recently completed a degree in palliative nursing. During their studies, shifts were made flexible around university lectures and the member of staff was able to shadow the palliative care nurses in the trust.

Other ward nurses either had attended or were currently studying for a palliative care course based at the local hospice one day per week over a six-week period. This included sessions such as symptom management, drug calculations, dealing with palliative care emergencies, dementia, psychological disorders, communication, bereavement, spirituality and documentation.

The end of life coordinator told us that training sessions had been arranged, such as communication and recognising death. However; these were not well attended due to other work pressures in the trust.

**Multidisciplinary working**

There was good multidisciplinary working both internally and externally. Patients who were transferred to the last days of life pathway were referred to the trusts palliative care team. Doctors we spoke with told us they could discuss symptom management with the SPCT and were supported by them.

We observed a multidisciplinary meeting where health professionals of different grades discussed end of life patients. They included a consultant and team of three doctors, the ward manager, a student nurse, physiotherapist, occupational therapist and a social worker. The meeting included the importance of patients’ wishes and advanced care planning discussions with patients and those close to them as well as any need for symptom control support.

All documentation was kept together so that all health professionals completed the same paper records for patients. There was currently no electronic palliative care co-ordination system; although the rapid discharge team completed an electronic system that was accessed by the community end of life team and G.P’s.
The mortuary staff, bereavement officer, chaplains (including volunteers) and porters worked well with staff in the delivery of care to patients and those close to them.

A multidisciplinary meeting was held once a week, at a local hospice that involved hospital and community staff, where patients were discussed. The palliative care course attended by acute hospital nurses was also held at the local hospice and was well attended. End of life training was provided to both health and social care staff within the local area.

**Seven-day services**

The 'NHS Seven Day Clinical Standards' (2017), standard eight states that all patients on an end of life pathway must be seen daily by a consultant. NICE guidance (quality statement 10: 2018) states that specialist palliative care and advice should be available at any time of day and night for people approaching the end of life.

The end of life clinical co-ordinator and palliative care team were only available Monday to Friday between 9am and 5pm. This does not meet the recommendations outlined by NICE and was highlighted at our last inspection.

There was no access to specialist services, either consultant or palliative care team, at the weekend either face to face or by phone. The consultant told us that a patient, at end of life, may be reviewed at weekend but on an informal basis. Otherwise consultants on the wards would review patients.

The mortuary was open during weekdays, 9am until 4.30pm with an on-call system to cover evenings, night and weekends. An appointment system was in place for viewing of patients by those close to them.

The bereavement office was open during office hours with an appointment system for the collection of the death certificate and patient belongings, although some preferred to attend the ward.

There were two chaplains, although only one was currently working. This meant that there was a reduced provision. There was an on-call system and contacts with other faith leaders, if needed as well as volunteers who supported the service. There was no routine Sunday service unless volunteers were available, although there was a Saturday service. Chaplains also supported funerals for patients without financial provision by attending the crematorium ceremony one nominated day if needed.

**Health promotion**

There was a holistic approach to patients’ in need of in end of life care and specifically those in the last days of life. Assessments included in the patients record included physical needs such as comfort and nutrition and hydration as well as any spiritual and psychological needs.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training completion**

The trust did not provide any information about completion rates for MCA or DoLs training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We observed staff obtaining verbal consent from patients in the delivery of care and treatment.
There were patients identified, by a discreet symbol on the trusts electronic boards that indicated if a do not attempt cardio pulmonary resuscitation (DNACPR) form had been completed.

DNACPR records were positioned inside the front cover of paper records so accessible to all who needed to view the records.

We reviewed DNACPR forms for eight patients. We found that for three patients identified as lacking mental capacity, there was no mental capacity assessment undertaken or recorded in patient records. Two out of the three patients had a best interest decision documented. Four out of eight forms reviewed did not include that there was relative or next of kin involvement in the discussion which was not in line with the trust policy. Three of the eight forms did not include the designation of the doctor signing the form, although all forms were approved by a consultant.

**Is the service caring?**

**Compassionate care**

We observed staff, of all grades, providing compassionate care to patients and those close to them.

Feedback from patients, and those close to them, confirmed that staff treated them well and with kindness.

We saw staff interacting appropriately with patients and those close to them.

Patients were cared for in side rooms whenever possible where those close to them could visit outside of routine visiting hours. Information received from the trust showed that between April 2017 and March 2018, 162 patients (92%) were accommodated in side rooms.

When deceased patients were transported to the mortuary, a nurse always escorted the patient and porter. Porters were clear that there was a sensitive approach to transporting the patient including privacy and dignity through ward areas.

A bereavement questionnaire was provided to families to gain feedback about the service, however; no results were available at time of inspection.

**Emotional support**

All staff introduced themselves and communicated sensitively to ensure full understanding. Patients, and those close to them, were encouraged to ask questions and were given time to ensure they understood what was being said to them.

We observed staff providing emotional support to patients and those close to them. Leaflets provided from the bereavement office included signposting to support services.

There was a mental health liaison team available if needed; although; responsiveness varied we were told.

The specialist palliative care team identified a gap in patient support with young patients with mental health problems who had attempted suicide. A support group was established for families of young people who had committed suicide.

**Understanding and involvement of patients and those close to them**
Records we reviewed showed that discussions had taken place with patients and those close to them.

Staff were clear that care was for the patient and those close to them. There was open visiting for families with close members able to stay overnight.

Mortuary staff and porters explained how they were respectful and caring with deceased patients and those close to them.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

There was no dedicated palliative care ward in the trust. Patients who required end of life care were nursed on general wards throughout the hospital.

The palliative care team were based in the hospital and were only available from Monday to Friday between 9am and 5pm providing support to other health professionals as well as visiting and supporting the patients that had been referred in their last days of life.

**Meeting people’s individual needs**

An advanced care plan template had been developed and was now in use in areas including care of the elderly wards. It was completed electronically prior to discharge and included discussions of patient’s wishes regarding future needs such as preferred place of care. It also included involvement of any community support required. The plan was shared with the G.P. and care home if applicable and a copy was kept in the patient records. It was also recorded in the discharge summary for any other health care professionals to view. A consultant, who specialised in elderly medicine, told us that G.P’s were very positive about the documentation and it was helping patients’ wishes to be upheld.

We reviewed 13 advanced care plans electronically. These showed detailed conversations had taken place with patients and those close to them regarding their future plans and their preferred place of care was clearly documented.

On all wards we visited staff were clear that, whenever possible, a patient in the last days of care, would be nursed in an individual side room. All staff we spoke with were passionate that patients at end of life were a priority and care should be the highest standard.

The last days of life documentation included an individualised care plan that was updated by all clinical staff. It also included a diary section for those close to the patient to complete.

In the accident and emergency department, we were told that if a patient needed to remain in the department then they would locate a side room on the clinical decisions unit, away from the main department.

Open visiting was available to those close to the patient. Overnight facilities for relatives and carers varied with sofa beds / recliner chairs or mats available to sleep on close to the patient. Rooms were available on each ward where visitors could access refreshments. There were dedicated visitors shower rooms near one ward. Free parking was also available to resident visitors.
Staff were aware of patients with dementia or a learning disability from the discreet symbols on the trust’s electronic boards.

There was a trust wide interpreter and translation service, although staff could access other staff members in the trust if required. For patients with hearing impairments there was access to a sign language specialist.

There was a range of patient information leaflets on the wards, including for end of life support for those close to patients, however; there were none in languages other than English or other formats such as ‘easy read’, large font or Braille. A bereavement pack was provided to those close to the deceased.

A mental health liaison team was available if the patient needed extra support.

A chaplaincy service was available. There was on-site presence, currently for five days a week (Tuesday to Saturday) with on call coverage if required. Chaplains attended multi faith forums and could access support for a range of faiths. There was a chapel, prayer room and ablution room at the hospital. Chaplains supported staff as well as patients and those close to them including offering mindfulness sessions.

Staff in the mortuary knew who to contact for a variety of faiths and provided an understanding of religious protocol. The trust’s last offices policy provided guidance for staff regarding a wide range of faiths as well as instructions about any pacemaker or heart device. The mortuary was discreetly situated in the hospital with a dedicated entrance from outside. Viewings were carried out using an appointment system with families directed to a certain car park. Entry was by a secure bell entry that rang in the mortuary office. At the time of inspection, the bell was rung but all staff were in other areas of the mortuary and the bell was not heard.

Bariatric equipment (for larger patients) was available in the mortuary including a larger storage area and trolleys. Porters told us that they could transfer on the patient’s bed through the hospital with appropriate covering.

**Access and flow**

All staff we spoke with told us that when an end of life patient was transferred to the last days of care pathway including documentation, they were referred to the trusts specialist palliative care team. Referrals came from relatives and the hospice as well as nurses and doctors. Between March 2017 and February 2018, there were 551 referrals to palliative care, with 72% referred from acute wards. Following referral, 73% of patients were initially seen within one day of referral, 18% were within three days and the remaining 9% were first seen four days or more following referral.

There was no electronic flagging system or register for end of life patients admitted from the community, although staff would inform the team.

The specialist palliative care team supported patients, and those close to them, that had life limiting conditions with a referral criteria based on need rather than diagnosis. They assessed the need for intervention. For patients categorised as level one (low risk), advice was provided over the phone, level two would be initially assessed on the ward with advice to re-refer at a later date. For level three patients, these would be reviewed every two days whereas level four (high risk) patients would be visited several times a day.

There was a discharge liaison team of three senior nurses that facilitated rapid discharges for patients on the last days of care pathway to get home or to a care home. The discharge team also helped with patients with complex needs. The team were available between 7.30am and 4.40pm.
Monday to Friday and could access a live portal of available care home beds in the area to support patients to get a place close to their home.

End of life patients are those that are likely to die within the next 12 months. We found that patients were referred to the palliative care team, following referral from a consultant to be placed on the last days of life documentation when death was imminent.

The palliative care team facilitated discharges to the local hospice. There were guidelines for ward staff for fast track discharge process at SGH.

Information provided by the trust showed that from April 2017 to March 2018, there were 436 patients whose place of death was outside of an acute hospital. Of these patients, 72 (16%) had a care in the last days of care document in place. There were 354 patients (81%) who had a preferred place of death recorded.

Information provided by the trust showed there were 322 patients (74%) who had anticipatory medicines prescribed and 368 patients (84%) who had a DNACPR form in place. For the same time period, there were 719 patients who died at the hospital, of which 179 patients (25%) had a ‘care in the last days of care’ document in place and 99% had a DNACPR document in place. Of these 179, 84 patients (48%) had discussed preferred place of death.

Information provided by the trusts mortality and end of life care plan report showed that 37% of patients whose preferred place of death was hospital achieved this SGH.

For patients being discharged from the hospital, we were told that they were able to organise transport and any equipment needs either the same day or the next day. This has included discharge out of area as far as Scotland and could be done on a Saturday. We were told that discharge could not be facilitated on a Sunday as staff were unable to access the funding requirements.

We spoke with the frail and elderly assessment support team (FEAST). They explained that the service facilitates patients to access support for seven days, such as therapies, in the community to help prevent admission to hospital. This has included facilitating advanced care planning for end of life patients.

The mortuary had extra temporary storage available if needed to fulfil any increased demand due to recent winter pressures, although not required at time of inspection. Staff reported good relationships with local funeral directors who were prompt in collection of the deceased.

Learning from complaints and concerns

Summary of complaints
From February 2017 to February 2018 there was one complaint about end of life care. The trust took 215 calendar days to investigate and close the complaint, this is not in line with their complaints policy, which states complaints should be completed in 30-45 working days or 60 working days for complex complaints.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We saw that information about providing feedback to the trust was available in all wards we visited.

Compliments
The data provided by the trust included no compliments for this core service; however, these may have been allocated to the wards or specialties that provided palliative care for patients.
We observed a number of thank you cards in areas we visited, however; staff did not record these on their electronic system.

**Is the service well-led?**

**Leadership**

There was a palliative care consultant who led the service, however; changes in the executive team meant that it was not clear who championed the service and represented on the executive board. In addition, there was no service improvement lead for the service.

Following the inspection, the trust told us that the chief nurse was the executive lead as well as the interim medical director being executive lead for mortality.

There was a non-executive director (NED) who was nominated to be responsible for end of life care. The consultant told us that the NED was supportive when needed.

The mortuary was led by pathology services as part of a regional service. The bereavement officers worked closely with the mortuary.

The end of life clinical co-ordinator and palliative care team were managed within the nursing directorate.

**Vision and strategy**

At the time of the last inspection, a strategy was developed that included seven work streams. Senior managers told us that the strategy was currently being reviewed to reflect the provision of the service in localities.

The trust vision and values were displayed throughout the hospital.

The end of life strategy implementation group had produced a work programme that included areas highlighted following the last inspection although there were no completed actions.

The palliative care consultant told us that the strategy implemented in 2016 was currently being reviewed to meet the needs of the communities served.

**Culture**

We observed good teamwork and senior nurses reported being proud of all staff and the care they provided.

There was a positive culture with staff reporting feeling supported by their line managers. We were told that senior leaders were visible and had visited their wards.

**Governance**

There was a multi-agency strategy group and a trust strategy group that met to discuss the end of life service.

We reviewed minutes of meetings provided from the multi-agency end of life strategy group that were held in June 2017, October 2017 and March 2018. These meetings alternated with Northern
Lincolnshire and Goole end of life strategy group meetings with minutes received for January 2018 and April 2018. Agenda items included DNACPR, feedback from families, anticipatory medicines and training. The minutes identified that the service does not have a policy for patients who die in transit.

The end of life team presented a quarterly update report to the trust’s quality and safety committee, the latest being May 2018. We requested the latest action plan, for the service, following the last inspection, however; this was not received.

We requested details of any service level agreements in place, however; no information was received.

Management of risk, issues and performance

A risk register was in place for end of life care. We found that risks were not always identified, such as there was only one palliative care consultant.

There were no current external reviews of the service at the trust.

Dashboards monitored outcomes for end of life care at ward level and these were reviewed at the end of life strategy group meetings where information was shared.

Information management

End of life policies and procedures were available for staff to view on the trusts intranet. Each ward had a folder with paper copies, however; we found that the policies for anticipatory drugs and pain and symptom management in last days of life” included a review date of December 2017. There were updated current versions available on the trust intranet.

Patient records were paper-based including the last days of care documentation and the do not attempt to resuscitate (DNACPR) form. The discharge liaison team forwarded information electronically to community staff of nurses and G.P.

The mortuary completed a paper record book and an electronic system. The newly recruited mortuary assistant was inputting historical paper records as well as current records.

Engagement

The link nurses shared information from end of life meetings with other ward team members, however; the end of life clinical co-ordinator explained that attendance at meetings was low during times of hospital pressures.

The service had held an end of life conference that included external speakers and was preparing for ‘dying matters’ week with events organised to raise public awareness. The evaluation of the conference by staff who attended was very positive.

A newsletter for end of life was developed by the end of life co-ordinator and shared with staff throughout the trust providing information and updates about the service provided.

Learning, continuous improvement and innovation

Latest guidance was discussed in end of life meetings, although implementation was prioritised due to the constraints of the service.
There were plans to launch the recommended summary plan for emergency care and treatment for patients (ReSPECT). ReSPECT is a process that includes personalised care for a person’s clinical care in a future emergency in which they are unable to make or express wishes. It provides health and care professionals responding to an emergency with guidance to help them make decisions about care and treatment.

There were plans to share the trusts electronic palliative care template with G.P’s leading to the setting up of an electronic palliative care co-ordination system (EPaCCS).
Outpatients

Facts and data about this service

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

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

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

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

Total number of appointments compared to England
The trust had 385,505 first and follow up outpatient appointments from November 2016 to October 2017. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)

Number of appointments by site
The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from November 2016 to October 2017.
<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>216,993</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>169,060</td>
</tr>
<tr>
<td>Goole &amp; District Hospital (Acute)</td>
<td>34,481</td>
</tr>
<tr>
<td>This Trust</td>
<td>420,534</td>
</tr>
<tr>
<td>England</td>
<td>103,843,026</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from November 2016 to October 2017. The percentage of these appointments by type can be found in the chart below:

The number of appointments at Northern Lincolnshire and Goole NHS Foundation Trust from November 2016 to October 2017 are shown by site and type of appointment.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

There is only one medical/dental staff member allocated to outpatients in the data received from the trust. This member of staff has completed seven out of 10 modules, all with a 100% completion rate. Three modules were not completed.

A breakdown of compliance for mandatory courses for nursing staff in outpatients from February 2017 to January 2018 shown below:
Nursing staff at Scunthorpe General Hospital met or exceeded the trusts 85% completion target for all mandatory training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with told us that mental health training was provided as part of mandatory training at the trust.

Staff we spoke with told us they had no difficulty accessing training courses. Some training had been cancelled due to winter pressures but staff were booked to attend future sessions.

Mandatory training records were managed centrally, but we saw outpatient’s managers also kept local training records and received updates on staff attendance through the trust’s electronic staff record system. Staff were booked to attend future courses to ensure compliance for all training.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

There is only one medical/dental staff member allocated to outpatients in the data received from the trust. This member of staff has achieved 100% completion for all three safeguarding modules.

A breakdown of compliance for safeguarding courses for nursing staff in outpatients from February 2017 to January 2018 is shown below:
| Safeguarding Adults (Level 1) | 27 | 27 | 100% | 85% | Yes |
| Safeguarding Children (Level 2) | 26 | 27 | 96% | 85% | Yes |
| Safeguarding Children (Level 1) | 26 | 27 | 96% | 85% | Yes |

Nursing staff at Scunthorpe General Hospital met or exceeded the trusts 85% completion target for all safeguarding training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

All staff we spoke with were able to describe their responsibilities regarding safeguarding concerns. They were able to give examples of the types of abuse, for example neglect, physical, domestic violence, sexual and psychological abuse. Staff gave us specific examples of safeguarding concerns they raised. Staff were clear how to escalate issues and felt they were well supported if they needed to discuss any concerns.

We saw that staff had access to safeguarding policies available to them through the ‘Hub’, the trust staff intranet. This also included guidance for staff regarding abuse such as female genital mutilation (FGM). FGM is defined by the World Health Organisation as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’.

Children attended some clinics, within the main outpatients department. The numbers of children attending were negligible. However, no staff working in the clinic had completed safeguarding level three training but all staff had completed levels one and two safeguarding training specific to children. Staff we spoke with explained the trust employed a safeguarding lead and the safeguarding team provided safeguarding information and support for adults and children’s safeguarding to staff on each site.

**Cleanliness, infection control and hygiene**

All areas we visited were visibly clean and tidy.

We saw cleaning schedules were in place to ensure rooms were clean prior to the clinic start times. Domestic staff we spoke with told us they used cleaning schedules and checklists to follow. We saw checklists were signed and up to date. All the rooms in main outpatients had been cleaned on the day of the inspection.

In the areas we visited, all seating in the waiting areas and couches in the consulting rooms were in good condition without rips and tears and were wipe clean. The areas were free from clutter and there was sufficient space for patients and staff to move freely.

We saw that staff adhered to bare below the elbow protocols.

We saw clinic staff participated in hand hygiene audits and compliance was 100% for every month.

**Environment and equipment**

The outpatients departments were located on upper floors within the hospital and were well signposted with lifts to enable easy access for less mobile patients.

Waiting areas were along the corridors outside consultation and treatment rooms with little space for wheelchairs, prams or buggies. We observed staff helping patients and directing them to treatment rooms. One patient we spoke with told us the ophthalmology clinic waiting area was never overcrowded.
We observed two toilets for disabled visitors were closed with out of order signs. There were no directions to the next available disabled toilets.

The phlebotomy area was located within the pathology department, immediately adjacent to the pathology laboratories. At first sight, the waiting area appeared crowded but we saw the waiting time was very short and a constant flow of patients had blood taken for testing. We saw patients were prioritised in order of clinical need. The phlebotomy waiting area had toilet facilities, including disabled toilets.

Staff we spoke with told us and we saw some areas of the building were old and several reports had been made to estates for repairs to be carried out, in particular to toilets. All rooms we saw were light and airy. However, some areas including examination rooms had walls with flaking paint. Staff we spoke with told us this was not a problem and was merely decorative. Resuscitation equipment was available on trolleys at various locations in the main outpatient areas and near other clinics. Daily checks were completed and tamper proof numbered tags were used to show if the contents had been accessed. Full internal checks of the trolleys were completed weekly. We examined the checklists of trolleys and saw that appropriate stock was in place and was regularly updated. One trolley had some significant gaps in checking dates. Staff had signed to show the contents of the trolley had been checked for only one week in April 2018 and the form for the rest of that month was blank. Only a few dates in May were signed to show the trolley had been checked.

Utility rooms were visibly tidy and equipment was stored appropriately. Sharps bins were checked throughout the outpatient areas and all were appropriately labelled, signed and the contents were all below the fill lines. We saw that waste bins were available to enable waste to be segregated appropriately.

All staff we spoke with told us they had sufficient personal protection equipment (PPE) such as gloves and aprons.

Equipment we observed was visibly clean and staff used ‘I am clean’ stickers to show when items had been cleaned.

We checked a range of items including, syringes and dressings. We found all items were within expiry date and staff confirmed that processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

Medical equipment was serviced on site. Staff we spoke with told us that technicians usually responded quickly to requests for checks and repairs. We checked six pieces of equipment and saw that they were visibly clean; four were within service date and were safety tested. However, two items had no service or electrical checking data. This information was given to the manager who immediately reported both items to the estates team.

Assessing and responding to patient risk

At our last inspection in 2016, the outpatient management team told us they had developed a clinical validation policy that had been agreed by all specialties to manage the risks posed by lengthy waiting lists.

The management team told us clinical staff were validating waiting lists with a view to prioritising patients for clinic review and discharging patients where appropriate. Alongside this, administrative staff had reviewed waiting lists to cleanse data. For example, ensuring those patients not requiring follow up were removed. At this inspection we were told similar information but some staff we spoke with explained the work had been completed and finished as a single project and not maintained. This meant that new waiting lists had developed and staff we spoke with at this inspection provided the inspection team with different figures and measures relating to numbers of
new and follow up patients waiting for appointments. We were not assured that there was clear oversight of the waiting lists and the risk posed to patients.

Following our inspection, the trust provided information which showed that waiting Lists continued to be reviewed on a regular basis and a daily validation report was in place.

At our last inspection we noted the centralised clinical administration appointment bookings team was significantly under established and did not have the training and support in place for their roles and responsibilities. At this inspection staff we spoke with told us that around 400 staff had received referral to treatment training. However, we noted these staff were administrators and not clinicians. Staff we spoke with could not give us a definitive explanation as to which staff were validating waiting lists.

Staff we spoke with told us the trust was carrying out a clinical harm review for all patients on waiting lists. Managers we spoke with told us clinical validation was ongoing in a number of specialities and specialty consultants were responsible for the validation and how they mitigated the risks. However, it was not clear if this had commenced in all specialities.

The clinical harm group identified that 181 patients had died whilst waiting for a follow-up appointment. At the time of inspection staff told us there had been no formal reviews of these deaths to see whether the delay in appointments or treatment may have contributed to the patient deaths.

The Trust created a new post to manage clinical administration and patient access. A Project Director had been appointed on a fixed term basis to manage the clinical harm project. They had introduced an electronic reporting system to identify all patients requiring review and a new outpatient data collection form for all clinic staff to use to ensure all follow up information was available. Patients were asked to hand their form to the clinic reception staff following any outpatient appointment. Staff we spoke with were confident this new system ensured patient details were captured and follow up arrangements were made before patients left the department. They felt this process would prevent any more patients being lost to follow up. However, staff did explain that numbers of patients waiting for appointments were increasing month by month.

At our last inspection we noted discharge and referral data showed an initial peak of activity where numbers of discharges declined then started to rise again, gradually reaching a peak in September 2016. This corroborated what staff had told us about clinical validation of waiting lists stalling for several months following the initial activity following our last inspection. This appears to have been a repeating pattern over the last three years with a lack of progress made because once numbers were reduced the project was closed. This lack of progress meant that numbers of patients waiting for follow up continued to accumulate and at this inspection numbers were higher at 31,295 patients on the waiting list in March 2018.

At our last inspection managers told us that work with NHS Improvement (NHSI) had included looking at the reasons why there was a mismatch between demand and capacity, quantifying the capacity and demand in each speciality and risk rating each of the specialities. At this inspection specialty managers told us meetings were being held with managers, consultants and administration staff to review the waiting list position and to manage and prioritise capacity and demand for appointments.

The trust had appointed a cancer project lead in October 2017 whose role was to address diagnostic delays and the trust’s decline in performance for 62 day waits for treatment for cancer patients. They told us their aim was ‘to change the outcome in some troubled specialties’. Staff we spoke with told us the trust used cancer service coordinators to input patient details and multidisciplinary teams (MDTs) worked together to assess individual patient needs. However, the trust cancer lead told us they estimated only 20% of clinicians and 50% of specialist nurses took
part in cancer MDTs. They reported difficulties in getting clinicians to mark test requests with the correct priority therefore possibly delaying diagnoses.

Staff we spoke with reported long waiting times within specialties such as cardiology. They were seeing an increase in the number of cardiology patients waiting so long for pacing appointments they were being admitted acutely with urgent requirements.

At our last inspection, managers told us staff were ready to start real-time validation of patient tracking lists (PTLs). This would ensure waiting lists were managed appropriately and the quality of data input would be improved and prevent issues such as no due date and pathways being left open incorrectly. At this inspection staff we spoke with told us this work was continuing and they felt this ensured that patient outcomes (e.g. whether discharged or for further investigation, treatment or appointment) were correctly coded.

Staff we spoke with told us that if a patient became unwell during clinic they would seek immediate assistance from medical staff in the department. In the case of a patient collapse in the outpatient department, all staff we spoke with were aware of how to raise the alarm and raise a cardiac arrest call. Staff we spoke with told us they had managed three patients recently who had all suffered epileptic fits within the department. Staff we spoke with told us if they needed help with a situation they could call switchboard for the crisis team or security.

Staff we spoke with told us they had introduced an adapted ‘World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery’ prior to performing invasive procedures such as biopsies and intravitreal injections with a future plan to roll it out for outpatients. We reviewed 10 sets of patient notes but did not see the checklists used.

Staff we spoke with did not know of any formal process to follow for patients requiring mental health support or those living with learning difficulties. We observed staff relied on carers to provide information about patient needs and when we checked patient records we found no entries relating to individual patient needs.

Staff we spoke with told us they could contact the trust’s learning disabilities lead for guidance.

Nurse staffing

The trust did not provide any nurse staffing data for outpatients at SGH as part of our routine provider information request.

Outpatient managers managed nurse and health care assistant staffing levels depending on what clinics were running each day. Staffing was planned with individual specialties and was flexible to meet the clinic needs. Managers we spoke with told us staffing had not changed for a significant length of time but they expected the capacity and demand review would help to plan staffing in future.

The matron was newly appointed and had been in post for only four weeks at our inspection. They managed 100 registered nurses and health care assistants over the whole of the clinical support directorate.

The trust provided information on cardiac physiologist staffing levels at Scunthorpe Hospital. This showed there was one whole time equivalent for a band five vacancy, one whole time equivalent band seven vacancy and a 0.53 whole time equivalent band seven vacancy.

In echocardiography, the trust provided information showing there was two whole time equivalent band seven vacancies at Scunthorpe Hospital.

Vacancy rates

From February 2017 to January 2018, the trust reported a vacancy rate of 2.3% for nursing & midwifery staff in outpatients;
• The trust did not provide the vacancy rate for Scunthorpe Hospital.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

All senior staff we spoke with were aware of their vacancies at each clinic. Staff we spoke with told us that shifts were covered internally and no agency staff were used.

Patients we spoke with told us they thought there was enough staff in the areas visited.

**Turnover rates**
From February 2017 to January 2018, the trust reported a turnover rate of 23% for nursing & midwifery staff in outpatients;

• Scunthorpe General Hospital: 30%

All three sites did not meet the trusts turnover target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**
From January 2017 to December 2017, the trust reported a sickness rate of 5.8% for nursing & midwifery staff in outpatients;

• Scunthorpe General Hospital: 4% met trust target of 4.1%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staff we spoke with at Scunthorpe explained there had been a higher than usual sickness rate and this did have an effect on staff morale.

**Bank and agency staff usage**
From February 2017 to January 2018 the trust did not employ any bank or agency staff within outpatients.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical staffing**
Medical staffing levels were managed by the individual specialities across the trust. Some specialties reported several consultant vacancies with posts proving very difficult to fill and we saw this had a direct effect on the trust’s ability to manage new and follow up appointments.

**Records**
All patient records were paper based. However, patient letters including referral letters and all diagnostic results were easily accessible via electronic systems. Staff we spoke with told us that if records were not located before a clinic then the administration team would make up a temporary set of records, which would be merged, with the original set when located.

The trust did not collect data regarding the percentage of patients seen without a full medical record. However, staff we spoke with told us this rarely happened and there was an escalation process in place for them to use when notes were unavailable for clinics.

We looked at the medical records of ten patients attending outpatient clinics. We
found these were of a poor standard, untidy, with poor legibility, and very scant information recorded, in particular by doctors regarding follow up appointments. This was not in line with professional standards or trust policy.

Record entries were mostly signed and dated but staff designations and times were missing. They contained up to date information about patients including referral letters, copies of letters to GPs and patients, medical and nursing notes.

At our last inspection we reported medical records were not stored securely. At this inspection staff we spoke with told us they did not carry out records storage audits but records were always locked away or covered and never left unattended. However, we found three separate areas in outpatient clinics where medical records were left uncovered, unsupervised and in open areas. To ensure confidentiality and data protection when not in use all medical records should be kept secure, in a locked room and away from public areas. Staff we spoke with told us they had looked into purchasing covers for notes trolleys but they had been unable to find anything suitable. Therefore, we found notes on open trolleys, stacked on the floor and stored in an unlocked room. We raised our findings with senior staff during our inspection but found on our return to the site the following day only one of these concerns had been addressed.

**Medicines**

Medicines in most areas were stored in locked cupboards and refrigerators.

We checked a range of medicines and found them to be in date and stored appropriately. Nurses who required access to medicines cupboards carried individual keys.

No controlled drugs (CDs) were stored in the areas we inspected.

Staff monitored and recorded the temperature of the rooms where drugs were kept. We reviewed the temperature records in clinic rooms and saw that daily checks had been completed. We saw the temperatures were within acceptable limits. Staff we spoke with could explain the process to follow should temperatures fall outside the required range. Clinicians used a mixture of electronic prescribing and FP10 prescriptions. The FP10 prescriptions were securely stored in a locked cupboard. Prescription records were kept securely and separately from prescription books.

We saw a number of patient group directions (PGD) were used across a number of clinics, including ophthalmology and cardiology. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2017 to December 2017, the trust reported no incidents classified as never events for outpatients.

*(Source: Strategic Executive Information System (STEIS))*
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from January 2017 to December 2017.

Both incidents were classified as treatment delay meeting SI criteria with two (100% of total incidents).

(Source: Strategic Executive Information System (STEIS))

The CQC received information on 19 June 2018 that the trust declared a serious incident on 18 May 2018 that was found during a validation exercise. A patient had been missed from the cancer tracking system and was treated on a routine 18-week pathway but went on to be diagnosed with cancer. The patient did not receive treatment until day 212 in their pathway. Staff we spoke with told us that they were able to log onto the intranet and review never events and serious incidents across the trust and the learning from these incidents. Staff shared learning from incidents across the outpatient departments of three hospitals within the trust. Managers shared alerts and actions for change following incidents with staff at formal meetings and managers' rounds at the start of each shift.

All staff we spoke with understood the incident reporting process and described how they would report an incident. Staff we spoke with told us that incidents were shared through emails and staff handovers where staff received feedback on incidents and learning was shared.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Local policy and national documents relating to duty of candour were available via the trust intranet. Staff that we spoke with were aware of the need to be open and honest when something went wrong and we saw duty of candour posters displayed in patient waiting areas.

Safety thermometer

The safety thermometer was not used in outpatients. However, outpatients did record and display hand hygiene audit results. Senior staff completed a monthly ‘A3’ outpatient dashboard that showed performance data which was shared with staff and trust management.

Is the service effective?

Evidence-based care and treatment

Staff had access to a trust intranet which contained the trust policies and procedures available to staff. Staff we spoke with told us they worked within standards and guidance applicable to their practice.

Audit was generally carried out within the specialities that provided outpatients. Staff we spoke with told us they were notified of audit requirements from the trust’s governance team. Staff in ophthalmology told us they participated in national audits, for example the national cataract audits. Podiatry took part in national audits such as a diabetic foot audit annually and we were told the results were above the average nationally. The podiatry team were part of a clinical network for diabetic foot conditions.
Respiratory outpatient’s staff we spoke with told us they participated in national audits such as the asthma audit and chronic obstructive pulmonary disorder audit. Staff in the ear, nose and throat clinic told us they completed scope audits to check cleanliness.

We were told during our inspection that national audits were generally managed at trust level and staff would be informed when audits were required to be completed. Senior managers told us that outpatients was part of the clinical support services audit programme.

The podiatry team had a set referral pathway for the service and diabetic foots pathways for example.

**Nutrition and hydration**

Staff we spoke with in outpatients told us they were able to provide drinks to patients who had waited a long time or who required a drink. They were also able to provide food to patients if required in the outpatient clinics. Some areas we visited had water dispensers available.

**Pain relief**

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

**Patient outcomes**

Audits were carried out in outpatients but these were managed by the individual specialities providing the clinics. Outpatients as a service did not generally monitor patient outcomes. Patient outcome data was managed by the individual specialities.

**Follow-up to new rate**

From November 2016 to October 2017,
- The follow-up to new rate for Scunthorpe General Hospital was similar to the England average.

**Follow-up to new rate, Northern Lincolnshire and Goole NHS Foundation Trust.**

(Source: Hospital Episode Statistics)

**Competent staff**
Staff we spoke with told us they received training in addition to their mandatory training. Staff we spoke with told us they had received annual appraisals. Some staff in ophthalmology had completed dementia training to provide further understanding of dementia, training on eye drops and visual field test competencies. Staff we spoke with in orthopaedic outpatients had received dementia awareness training.

We were told that phlebotomy staff completed internal training and had reviews of competency every two years. There were two stages of training which included theory and practical training. Pathology offered training to different staff in the department.

Some staff we spoke with told us they received clinical supervision and other staff had been supported to complete prescribing courses and additional studies.

There were clinical nurse specialists available in some clinics in outpatients, for example dermatology. Clinical nurse specialists in urology outpatients told us they had attended additional training and attended a urology conference.

Around 400 staff in the service had completed training in referral to treatment indicators and the access policy to increase their knowledge of these.

Senior managers we spoke with told us there was line manager training available.

One member of staff we spoke with told us they felt ‘totally unsupported’ in their requests to undertake training in order to progress in their role.

Some staff attended external regional meetings applicable to their practice.

**Appraisal rates**

From April 2017 to March 2017, 100% of nursing staff within outpatients at the trust had received an appraisal, this met the trust target of 95%.

A breakdown by site is shown below;

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>13</td>
<td>13</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
<tr>
<td>Goole District Hospital</td>
<td>3</td>
<td>3</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>13</td>
<td>13</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>29</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Source: Routine Provider Information Request (RPIR) P43 Appraisals*

**Multidisciplinary working**

Ophthalmology had multidisciplinary team meetings which were held at Scunthorpe Hospital and oncology had multidisciplinary team meetings at each site. The podiatry team had multidisciplinary team meetings which included staff from the diabetes speciality.
Clinical nurse specialists were available in a number of clinics visited to provide further support and advice to patients. There was multidisciplinary team working in outpatients with medical staff and nursing staff working together along with clinical nurse specialists in departments such as cardiology.

We were told that each Friday there was a urology multidisciplinary team meeting.

The trust had recently started a one stop clinic for diabetes involving a consultant, clinical nurse specialist, dietician and podiatrist.

**Seven-day services**

Seven-day services were generally not provided by outpatients.

Managers told us the pathology laboratory was open 24 hours a day with on-call staff available.

**Health promotion**

Outpatients had held smoking cessation groups. There were patient information leaflets available in different outpatient specialties.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff we spoke with in ophthalmology told us they had recently received mental capacity act training.

The oncology pre-assessment clinics had consent paper work for use in clinics. Staff we spoke with were able to talk about taking consent. Podiatry and therapies used electronic record systems and this allowed consent to be recorded on the system.

We found one DNACPR form within patient notes that was fully completed with evidence of joint decisions made.

The trust provided details on mental capacity act training compliance for outpatients. This showed 88.7% of staff had completed the training against a trust target of 85%.

**Is the service caring?**

**Compassionate care**

We spoke with nine patients and three relatives and those close to them. Overall, the feedback was positive and staff were described as being kind, caring and considerate. Patients we spoke with told us they felt supported and treated with dignity and respect.

We observed staff of all grades interacting with patients. Staff introduced themselves, were friendly and welcoming and were quick to offer help when required. The outpatient survey showed that 86% of respondents stated that staff members introduced themselves when they came into direct contact with them. The outpatient survey did not detail the date of the survey.

Administrative staff, volunteers and nurses all greeted patients on arrival to main outpatients.

The trust provided a voluntary transport service for patients unable to make their own way to appointments. Patients we spoke with told us they found it invaluable and very efficient.
The trust provided an outpatient department patient questionnaire for Scunthorpe Hospital; however, this did not have a date attached. One hundred percent of respondents felt they were treated with dignity and respect. Fifty one percent of respondents said their overall experience on the day was excellent, thirty nine percent stated good and five percent stated average and five percent stated a poor experience.

**Emotional support**

The urology outpatient’s team provided patients with contact cards.

Clinical nurse specialists provided additional support and in depth knowledge to patients with a range of conditions and disease specific information. Staff we spoke with told us about specific support they provided such as catheter care for urology patients. Staff provided a wide range of leaflets to support patients at appointments and to enable self-care at home. Specialist nurses in ophthalmology gave patients their contact details so they could escalate any change in condition or seek advice when they needed to.

One ophthalmology patient we spoke with told us there was always someone to talk to and they had been given contact numbers for Scunthorpe and Goole clinics with instructions to ‘get in touch with any worries after my op’.

We saw information about the availability of chaperones in the main outpatient waiting room. Staff we spoke with told us that they were able to provide a chaperone when it was required. The majority of outpatient staff were female but there were male members of staff available when requested.

Patients we spoke with told us they felt involved in the planning of their care.

**Understanding and involvement of patients and those close to them**

There was a sign at the outpatient reception regarding patient privacy at the reception desk.

We observed staff interacting with patients and relatives in clinics and imparting information in a way that was appropriate for the patient’s understanding. One patient told us ‘the appointment letter had all the information I needed’.

Patients received a copy of the letter sent to their GP following consultations. This ensured that patients were kept up to date with all decisions made about their care.

Staff directed patients to a range of appropriate support agencies and self-help groups.

The trust provided an outpatient department patient questionnaire for Scunthorpe Hospital; however, this did not have a date attached. This showed that 54% of respondents felt relaxed regarding their experience of the department, 13% had a reasonable experience, 9% felt nervous and 24% felt staff did their best to put them at ease.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Volunteers were available to assist people with directions at the hospital. Patients could check in at a reception desk or use the electronic check in desks at outpatients. There were seating areas in the different outpatient areas at the hospital; however, there were no bariatric chairs available for use in waiting areas in outpatients.
Ophthalmology outpatient clinics times were Monday to Friday 8:30am to 6pm. Outpatient’s clinics generally were open between 8am and 4:30pm Monday to Friday. The phlebotomy service was available in outpatients between 8am and 5pm Monday to Friday.

Phlebotomy outpatients had seating available for patients and a reception desk for patients to book in. Podiatry outpatients had water available for patient use, patient information leaflets, for example on diabetes, magazines in the waiting room and seating for patients waiting for clinics.

Outpatient clinics could offer patients a bleep if the waiting times in clinic were long and staff would call the bleep when their appointment was ready.

Senior managers we spoke with told us they met regularly with the clinical commissioning groups regarding service delivery and attended regular business meetings for outpatients. Capacity and demand was managed by individual specialities.

There were limited clinics which had put on extra evening and weekend clinics to address backlogs and provide additional appointments. Ophthalmology had two evening clinics a week on a Monday and Tuesday between 5pm and 8pm. Staff we spoke with told us these clinics were well attended. Orthopaedic outpatients had also held evening clinics. There had been limited weekend clinics in ophthalmology and neurology outpatients.

Virtual clinics were provided in ophthalmology by the medical illustrator service who completed a visual acuity test, scan and optical coherence tomography (OCT) which is an imaging technique and these were then reviewed by a consultant a few days later. There were four virtual clinics each week. Staff we spoke with told us there was a new virtual clinic being initiated for diabetic patients. These virtual clinics did require the patient to attend clinic.

**Meeting people’s individual needs**

Bariatric equipment was not routinely available in ophthalmology outpatients; however, staff could request bariatric equipment from another ward if required. Staff in orthopaedics told us they would arrange for a different location to be used if bariatric equipment was required as the department did not have access to bariatric equipment.

Outpatient clinics we visited had a range of leaflets available for patients. Some areas provided these leaflets in different languages.

Some areas had dementia friendly environments, for example clocks and toilet signage. Staff we spoke with in outpatients told us that they would try to get dementia patients into clinic as promptly as possible and would ensure a quiet area was available for use if required. There was a dementia team in the trust that staff could call for advice.

Staff in ophthalmology told us they were able to provide a quiet room for vulnerable patients attending clinics and were able to prioritise vulnerable patients if required.

There was no direct access to mental health advice for staff in outpatient departments. Staff would refer patients to the emergency department if required.

There was a dementia link nurse and learning disability link nurse at Scunthorpe Hospital. Three of the nine patients we spoke with told us they had received no information about follow up appointments for respiratory and ophthalmology clinics and had had to request appointments several weeks or months after they felt they were due to be seen.

The outpatient survey the trust provided showed that 91% of respondents found the environment in the waiting room pleasant and comfortable.
Access and flow

The previous inspection found concerns with waiting lists and referral to treatment indicators. During this inspection we found there were still issues and concerns around waiting lists for appointments and most specialities were not achieving their referral to targets indicators.

The planned care key performance indicator dashboard showed there were 31,295 follow up outpatients overdue as at March 2018. Senior managers told us that around 14,518 of these were part of the clinical harm review and 6000 were patients who did not have a review date assigned. The previous inspection found that not all patients had a due date on the patient administration system. During this inspection, senior managers told us there were still patients without a due date on the patient administration system; however, managers told us they knew who these were and were working through the 6000 patient backlog for due dates. We were told 2000 of these patients could not have a due date for follow up appointments as they were waiting for an inpatient episode.

The planned care key performance indicator dashboard April 2017 to April 2018 showed there were 320 patients waiting over 52 weeks for an appointment at the trust as at March 2018.

The previous inspection found that the trust aimed to achieve their referral to treatment required position by March 2018. During this inspection, this had not been achieved and senior managers told us there was an action plan for medicine and surgery but the trajectory for improvement and for achieving the referral to treatment indicators and follow up appointments would not be decided until the end of quarter one (June) 2018. Senior managers told us there had been some recent improvement in cardiology where the backlog was 3,600 waiting for follow up appointments and the service had reduced this to 3,300 in the previous six weeks.

The services had worked with the intensive support team to create a capacity and demand model and the focus initially was on the eight most challenged specialities. The capacity and demand plans were being completed by individual specialities at the trust.

The trust provided an improving together programme document for the outpatients and patient access work stream highlight report which showed information such as key activities last month and next month, key performance indicators and top risks and issues.

The trust provided a project document for outpatients. This detailed the project scope and work stream risk log. The trust also provided a project brief for outpatient efficiencies and patient access which was dated October 2017 and included a project plan.

The previous inspection found issues with the trust’s recording of some referral to treatment indicators in outpatients. Senior managers told us that they had started to audit recording of some indicators and waiting lists at the trust; however this had only happened in five specialities at the time of the inspection.

Individual clinics and specialities booked appointments for patients and patients would contact these clinics directly if required. Staff we spoke with were aware there were long waiting times for clinic appointments.
We saw in outpatient clinics we visited that staff would highlight the waiting times for clinics on display boards in the waiting areas. Staff would also inform patients verbally if the wait in clinic was longer than expected.

The trust had implemented a national key performance indicator dashboard which included ‘did not attend’ (DNA) rates and appointment slot issues (ASI). Information provided by the trust following the inspection showed that they were making progress to reduce DNA’s and ASI’s in line with national or commissioner agreed trajectories.
One patient reported they hadn’t received a follow up appointment after their initial visit. They had phoned after four months to ask what was happening and had received an appointment. Another patient told us they had been told they needed a CT scan at their appointment in October but after hearing nothing by January they asked their GP what was happening. The GP chased up the CT scan appointment in January 2018 and the follow up was in May 2018.

An outpatient patient survey at Scunthorpe General Hospital showed that 55% of patients waited 0 – 15 minutes longer than their appointment time, 14% waited 15 – 30 minutes longer, 12% waited 30 – 45 minutes longer, 9% waited 45 – 60 minutes longer and 10% waited 60 minutes or longer.

The same outpatient patient survey showed that 42% of respondents were given an explanation of the appointment delay by staff.

**Did not attend rate**

From November 2016 to October 2017,
- The ‘did not attend’ rate for Scunthorpe General Hospital was higher than the England average.

Although Scunthorpe General Hospital had the highest ‘did not attend’ rate across the three sites, the overall performance for all hospitals generally follows the same trend with their worst rates in November 2016 which improve towards the end of the reporting period.

All three sites are generally higher than the England average from November 2016 to October 2017.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Northern Lincolnshire and Goole NHS Foundation Trust.

---

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for November 2017 showed 75.3% of this group of patients were treated within 18 weeks versus the England average of 88.8%.
Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Northern Lincolnshire and Goole NHS Foundation Trust.

![Graph showing referral to treatment rates for non-admitted pathways, Northern Lincolnshire and Goole NHS Foundation Trust.](image)

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

One specialty was above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>98.8%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>97.4%</td>
<td>93.8%</td>
</tr>
</tbody>
</table>

Fourteen specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>86.5%</td>
<td>88.1%</td>
</tr>
<tr>
<td>Other</td>
<td>86.1%</td>
<td>91.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>83.8%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>83.0%</td>
<td>87.2%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>82.2%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.5%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>76.3%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>72.1%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>72.0%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>71.0%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>70.3%</td>
<td>90.2%</td>
</tr>
<tr>
<td>ENT</td>
<td>69.3%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>63.7%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Neurology</td>
<td>24.5%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance.

In the latest month, November 2017 73% of this group of patients were treated within 18 weeks compared to the England average of 89%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Northern Lincolnshire and Goole NHS Foundation Trust.
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

One specialty was above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>96.6%</td>
<td>90.6%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

(Cause: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Northern Lincolnshire and Goole NHS Foundation Trust

(Cause: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Northern Lincolnshire and Goole NHS Foundation Trust

The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Northern Lincolnshire and Goole NHS Foundation Trust

(Source: NHS England – Cancer Waits)

During our inspection senior staff we spoke with told us there was no current target date for improvement of the 62 day wait and an action plan was being developed to address the issues.

Learning from complaints and concerns

Summary of complaints

Scunthorpe General Hospital:

From February 2017 to February 2018 there were 66 complaints about outpatient services at Scunthorpe General Hospital.

The trust complaints data shows these mapped to specialities. The top specialities with most outpatient complaints at Scunthorpe were orthopaedics with nine complaints and cardiology and ophthalmology with five complaints each.

The trust took an average of 45 working days to investigate and close complaints at the hospital. This is not in line with the trust targets for closing complaints within 30 working days, but just meets the further target of 45 working days.

A breakdown of the subject of complaints is shown below:
• Patient care – 31 complaints
• Appointments – 12 complaints
• Access to treatment or drugs – nine complaints
• Communications – seven complaints
• Waiting times – four complaints
• Values and behaviours of staff – two complaints
• Facilities – one complaint.

(Source: Trust Provider Information Request P55)

There was evidence of complaints which related to access to treatment, for example in ear, nose and throat outpatients.

Staff we spoke with told us a complaint regarding waiting times in phlebotomy outpatients had led to the service creating a waiting time monitoring system to reduce waits and alert staff to if additional staff were required. Staff we spoke with told us complaints were often regarding waiting times in clinics and told us they had changed the boards in waiting areas to include the doctor’s clinic and the waiting times.

Staff we spoke with in ophthalmology told us they often attempted to address complaints informally in clinic and that complaints were discussed at team meetings along with lessons learnt.

There were posters providing information on how to complain to the service.

Is the service well-led?

Leadership

Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available for support when required. However, staff we spoke with told us senior leaders were less visible in departments. Staff views varied on the trust leadership team being visible in departments. Some staff we spoke with told us they had met the trust’s recently appointed senior leadership.

Outpatients were part of the clinical support services directorate.

There was a structure for the management of outpatients. Overall leadership was provided by the clinical support services senior management team. There was a matron for outpatients covering all sites. Scunthorpe Hospital and Goole and District Hospital were managed by a manager across both sites.

The clinical services directorate management group had been formed in June 2017.

Since the previous inspection, the trust had appointed a senior manager to address concerns with patient administration. Senior managers we spoke with told us work was progressing with clinical validation and training on logging the correct follow up with patient administrators and that the focus was on stabilisation and understanding of where the trust was with waiting lists. The aim was to reduce waiting lists and ensure visibility of waiting lists in a sustainable way.

Senior managers we spoke with were aware there were challenges with waiting lists for outpatient appointments and issues with referral to treatment indicators.

Vision and strategy
There was no documented strategy or vision for outpatients across the trust. Most staff we spoke with were not aware of the trusts vision and values. We saw the vision of the trust on display in some areas we visited, for example in main outpatients.

Senior managers we spoke with told us they were working with commissioners to address issues around capacity and demand. The trust had received previous reviews from external organisations of waiting list issues.

Senior managers told us their focus for the next twelve months was around waiting lists, managing capacity and demand, clinical harm reviews and patients waiting over 52 weeks.

The priority was to work with the patient administrative lead in outpatient to provide outpatient services. Capacity and demand was being managed by individual specialities.

**Culture**

The previous inspection found concerns around the culture of outpatients. During this inspection, most staff in departments told us there was good teamwork amongst department teams, openness and honesty in teams and overall staff were positive about working in their departments. Most staff we spoke with told us they felt supported.

Staff we spoke with told us morale was generally good; however, it could vary at different times and had been low in some services previously.

Staff at Scunthorpe explained there had recently been a higher than usual sickness rate and this did have an effect on staff morale. One member of staff we spoke with said they felt pressured by senior managers to accept extra bank shifts.

Staff we spoke with told us about a lack of communication from the senior leadership team in outpatients.

Outpatient managers told us they had an open door policy. Scunthorpe Hospital outpatients had a team meeting once a month and minutes would be sent to staff. Minutes from April 2018 showed that keeping the display board in outpatients up to date with in clinic waiting times was discussed.

**Governance**

Senior managers for outpatients described the governance arrangements. We were told that outpatients had a monthly governance meeting and then senior managers attended the clinical support services governance meeting. There were director level staff at this meeting where concerns and issues could be escalated to the board at the trust. The clinical support services group had a monthly meeting.

Outpatient managers attended the governance meetings.

The agenda from the December 2017 and April 2018 governance meeting showed that National Institute of Health and Care Excellence, national patient safety alerts, infection, prevention and control and the risk register were part of the agenda. Complaints, incidents and mandatory training were also part of the agenda for governance meetings in the clinical support services directorate.

Due to the issues around waiting lists and backlogs of patients for outpatients, the trust had started a clinical harm review group where they were reviewing around 14,000 patients for clinical harm. The previous inspection highlighted a number of issues and concerns around patients where no due date had been attached to the patient administration system, patients waiting over their due date, referral to treatment indicators not being met. At this inspection we found the management of these concerns and clinical validation had been slow to begin.
Since the last inspection, the trust had appointed a senior manager for patient administration and there was further documented information on the actual number of patients in the follow up appointment backlog and clinical harm review. We were told there were a number of different actions taking place to address the concerns and issues around waiting lists. Clinical and administrative validation of waiting lists was ongoing; however, this was not complete across all specialities at the time of this inspection.

Waiting lists were managed by the specialities they were part of, for example medicine and surgery managed their own waiting lists.

A staff member from the phlebotomy service attended a regular clinical governance trust meeting.

There was a quality and safety meeting every two months for clinical support services.

**Management of risk, issues and performance**

Managers had access to performance information such as staffing levels and sickness levels. Each outpatient department had a monthly performance report which detailed performance information that was used during meetings.

Outpatients had a risk register and we were told this was reviewed monthly and this was on the agenda for governance meetings. Senior managers we spoke with told us the trust had provided risk register training. The trust had an incident reporting system which staff could report incidents regarding outpatients.

The trust had failed to address concerns about waiting lists and complete clinical validation of patients in the waiting list backlog from the previous inspection in 2016. The previous inspection found that the trust was finding cohorts of patients which were not being effectively managed. We were told during this inspection that the 31,295 patients was the total number of patients in a backlog for outpatient appointments at the trust.

Pathology services had key performance indicators which managers told us they monitored monthly. Managers told us there was a turnaround time of one hour for urgent emergency department requests and we were told normally 90% of these were done on time. The target time for general practitioner requests to pathology was 24 hours if specialist analysis was required.

The trust provided us with an outpatient care key performance indicator dashboard from April 2017 to April 2018. This included various performance information such as did not attend rates and hospital cancellations.

Senior managers told us there were daily patient tracking list huddles in five specialties with team leaders, service managers and administrative staff and that each division had a weekly performance meeting.

**Information management**

Staff had access to electronic systems across outpatients, for example access to policies and procedures through the trust intranet and electronic incident reporting system.

Managers had access to performance information such as key performance indicator dashboards.

Senior managers told us there had been no recent information governance issues in outpatients.

**Public and Staff Engagement**
Senior managers told us there was a clinical support services newsletter for staff which included lessons learnt and we were told the trust had an open access physiotherapy service for staff and staff counselling.

Friends and family test surveys were carried out in outpatients; however, we did not see any results from these. Senior managers told us they also completed a quarterly patient satisfaction survey.

The trust provided information highlighting they did not complete staff surveys. Senior managers told us that the new senior leadership were meeting to work on priorities such as morale and had a listening into action campaign. There was a staff magazine and newsletter at the trust.

There had been four staff engagement workshops for the clinical administrative teams and nursing staff to address staff dissatisfaction challenges.

There were team meetings in different outpatient clinics for example in ear, nose and throat outpatients; however, some services such as ophthalmology and cardiology had not had regular recent team meetings.

**Learning, continuous improvement and innovation**

The podiatry team had won the star award 2017 at the trust. The ophthalmology team had also won the star award from the trust.

The pathology service were in the process of implementing a new monitoring system with a dashboard to identify any issues more easily. This dashboard would display sickness levels, complaints and compliments for example.

Orthopaedic outpatient’s staff we spoke with told us the vision was to hold more telephone led clinics and nurse led clinics in the department.

Whole slide imaging and digital pathology had been introduced in pathology and this had played a large part in meeting KPIs, improving productivity and reducing costs.

Pathology staff we spoke with told us they took part in several research trials.
Is the service safe?

Mandatory Training

The department made sure that all diagnostics and radiology staff had undergone specific training in handling radioactive and hazardous substances in line with their roles and responsibilities. The department had produced a workbook about the dangers of working in the radiology department for all staff including domestic and portering staff to complete to ensure patient and their own safety.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Medical staff worked cross site and the information for medical and dental staff is for all medical staff working in the diagnostics departments at Goole (GDH), Scunthorpe (SGH) and Diana Princess of Wales (DPOW).

All sites

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control - 1 Year</td>
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<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>3</td>
<td>5</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Mandatory training for allied health professionals

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level two</td>
<td>102</td>
<td>111</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level one</td>
<td>101</td>
<td>111</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>95</td>
<td>111</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>103</td>
<td>111</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>101</td>
<td>111</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
We spoke with staff working at SGH hospital about mandatory training. They told us that they were able to access training and that their manager would remind them when they needed to update.

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical and dental staff at across the trust is below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for medical and dental staff in diagnostics was 100% within the department with all modules except safeguarding adults level 1 meeting target.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for allied health professional staff (radiographers) Scunthorpe General Hospital is below. The training information about staff working at Goole hospital was included in the training data for Scunthorpe General Hospital because they shared the same manager as Scunthorpe General Hospital.

**Scunthorpe General Hospital combined**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level one</td>
<td>104</td>
<td>111</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level two</td>
<td>102</td>
<td>111</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level one</td>
<td>101</td>
<td>111</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust did not provide us with safeguarding training information for nursing staff who worked in
diagnostics and radiology therefore we were not assured that nursing staff were up to date with safeguarding training requirements.

Staff described to us how they made sure they were scanning the correct patient by using the three-point ID check. This made sure patients were not exposed to incorrect doses of radiation or unnecessary exposure. They made sure patient had the right scan first time.

Staff told us they knew about female genital mutilation and what action to take should they have any concerns about patients attending the department. There was information on the hospital intranet about how to report safeguarding concerns about patients. Staff also told us that if they were unsure what action to take, they would speak with their line manager, one of the doctors or the safeguarding team within the trust for advice.

There was information about safeguarding on the walls of the waiting rooms, visible where patients, visitors and staff could see it informing people who to contact if they had any concerns about vulnerable adults or children.

**Cleanliness, infection control and hygiene**

During our inspection we looked at the cleanliness of the departments we visited, the general radiology department and the Blue Sky suite. All the rooms in the departments were clean and uncluttered.

There were cleaning schedules in place and these showed regular cleaning of the department and the equipment being used. Staff wiped down x-ray machines between patients and used a disposable blue roll on beds. This was changed after every patient.

If a patient required isolation because of risk of infection, domestic staff carried out a thorough cleaning of the treatment room to prevent the potential spread of infection after treatment. If a patient was on a ward as an inpatient and needed an x-ray or ultrasound, portable equipment could be taken to the ward. Once finished, equipment was cleaned thoroughly to avoid contamination.

There were some toys for children to play with. These had only been introduced recently and were not included on the cleaning rota. When we looked at them, they were visibly clean.

There was sufficient personal protection equipment such as gloves and aprons available to staff.

There were processes in place to manage clinical waste within the department.

Hand hygiene audits were carried out in the department to ensure staff followed the correct hand washing procedures between patients. Results were good and we had no concerns about hand hygiene practice.

**Environment and equipment**

The department had resuscitation equipment in both the main radiology department and the scanning department. These were checked regularly in line with trust policy to make sure all emergency equipment was in place and in date.

There was clear signage outside and around the departments to warn staff and patients of the risks of radiation. X-ray rooms had illuminated signage to inform patients when it was safe and unsafe to enter and there were warnings for patients about MRI and CT scanner safety such as metal objects close to the MRI scanner. The signage was clear, visible and appropriate to the needs of the department.
All staff were allocated a dosimeter to wear. These were sent away regularly for monitoring and assessment. Any concerns with abnormally high doses were highlighted to the member of staff responsible. We spoke with this member of staff who described to us the action they would take if a dosimeter showed an abnormal reading. This was in line with the trust process.

All staff had lead aprons to protect them from over exposure to harmful rays. There were also aprons available for patients such as pregnant women when an x-ray was deemed as necessary, and parents or carers so they could accompany a patient in to the x-ray room. We saw evidence that the protective garments were checked and removed from service when no longer offering viable protection.

We looked at COSHH (Control of substances hazardous to health) policies and found them to be in date. Any substances hazardous to health such as cleaning products were safely stored. The department used specific radiology related contrast media on this site. This was stored safely and securely in a locked environment. Staff had individual keys that could show who had accessed the rooms.

Equipment in the main x-ray department was maintained in line with manufacturer requirements. There were maintenance and repair contracts in place. The medical electronics team within the trust was also able to carry out some repairs to broken down equipment.

Ultrasound equipment was new and of a high quality standard. Sonographers expressed no concerns about the capacity or ability of the equipment to fulfil their requirements.

Some of the equipment in the scanning department such as the MRI and CT scanners had experienced mechanical breakdowns over the past 12 months. SGH had experienced significant problems with mechanical breakdowns. This affected their ability to meet demand and meet key performance indicators (KPIs) and national treatment pathway targets. The equipment was on the risk register and some funding applications had been made to purchase new equipment however, at the time of the inspection these were still pending or the equipment had not yet been delivered.

The scanning department also had insufficient equipment to meet demand. Scanners were working from 7.30 am until 10.30 pm seven days a week to try to cope with demand yet waiting lists were increasing and waiting times for scans getting longer. This was recorded on the risk register but was an ongoing problem.

According the NHS Radiology benchmarking report for 2016/2017 activity, (the most recent report available) 20% of scanner and machines in this trust were leased. The trust was in the middle of the range of trusts who participated in benchmarking.

The same report showed the trust had more scanners than the average per 100,000 outpatient attendances (17 compared to 14). However, for A&E attendance, the trust had less scanners per 100,000 attendances, (two compared to three). For inpatients, the department had slightly fewer scanners per 100,000 bed days than the average (0.9 compared to 1).

The department had an old CT scanner located in Coronation block which was only used in an emergency if the regular scanner was out of service and a patient attended A&E with a suspected stroke. It was only suitable for head scans. National guidance states a patient with suspected stroke should have a CT scan within 60 minutes of arriving at hospital. This back up machine was used to ensure than any scanning delay for suspected stroke was not due to mechanical breakdown.

Staff told us the MRI scanner was a good scanner. It was supported by an MRI scanner hired from a private company, two days a week to assist with increasing capacity.
The department had business continuity plans in place to manage mechanical breakdown or IT system failures such as cyber-attacks. These were tested when the trust fell victim to a national cyber-attack. The department continued to function using analogue images rather than digital ones.

Assessing and responding to patient risk

Patients attending the scanning department requiring injection of contrast media or administration of other medication prior to their scans were scheduled to have their procedures during core hours when there was easier access to support services should patients have an adverse reaction.

Policies, procedures and local rules were in place for radiology. We checked these and found that the local rules in MRI had not been updated since 2014. Local rules elsewhere were displayed around the departments and in date.

There was a specific process in place for escalating unexpected or serious findings. This involved the radiographer requesting an urgent report and the reporting radiographer/radiologist calling the clinician who referred the patient to highlight the findings. However, we found four incidents where this system had not worked. One was for a patient with a missed spinal fracture, one for an x-ray with suspicious findings not escalated, one missed onward referral as a result if MRI showing suspicious findings and one where results from an urgent CT scan had not been acted upon and escalated. These four incidents had the potential to cause the patient harm. Therefore, we had concerns about the robustness of this process.

The trust had arrangements in place to seek advice from an external Radiology Protection Advisor (RPA) in accordance with relevant legislation. The hospital had a service level agreement (SLA) in place with the RPA at a neighbouring trust.

The RPA was easily accessible through regular meetings or telephone contact.

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. We saw evidence of this happening.

Radiation protection information was available in a folder and staff had all signed to confirm they had read it. This was the same across each department on each site.

All staff were observed to be wearing body dosimeters (dose meters) on the front of their torso. A radiation dosimeter is a device that measures exposure to ionizing radiation. 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 observed diagnostic reference levels (DRLs) were on display in the X-ray rooms. Risk assessments, including COSHH risk assessments, were all up to date.

Staff described how they would ensure pregnancy tests were performed for patients aged between 12 and 55 who were unsure of their pregnancy status. We saw pictorial representations were available for people whose first language was not English.

Imaging requests, which included pregnancy checks, were scanned into the patient’s electronic records. There were referral criteria which had to be met before a referral was accepted. Not all clinical staff could make a referral. This made sure only appropriate referrals were made, thus saving resources and reducing inappropriate referrals.
Systems and processes for the management of deteriorating patients were well established at SGH. Policies, procedures and local rules were in place for radiology. We checked and these were all in date and displayed around the departments other than MRI.

There was a specific process in place for escalating unexpected or serious findings. This involved the radiographer requesting an urgent report and the reporting radiographer/radiologist calling the clinician who referred the patient to highlight the findings. The manager confirmed the trust had arrangements in place to seek advice from an external Radiology Protection Advisor (RPA) in accordance with relevant legislation. The hospital had a service level agreement (SLA) in place with the RPA at a neighbouring trust. The head of general radiology told us the RPA was easily accessible through regular meetings or telephone.

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. We saw evidence of this happening.

Radiation protection information was available in a folder and staff had all signed to confirm they had read it.

The trust had not carried out any reviews of patients who had experienced delays, to find out if the delay had impacted on their condition, treatment or prognosis. We spoke with the general manager and clinical director who confirmed this was the case. This was the case for all three sites.

**Vacancy rates**

There were six radiographer staffing vacancies at SGH and one radiographer on long term sick.

**Turnover rates**

The trust has an annual turnover target of 9.4%.

Turnover rates data provided by the trust for staff in diagnostics covered only Goole District Hospital. However, staff and the manager we spoke with in plain film x-ray told us that staff turnover was a challenge because people came straight from university or overseas, stayed for a few years, gained experience and then moved on to other modalities or organisations where they were paid at a higher grade.

We spoke with radiographers on site at SGH. They told us that there was turnover of staff in plain film x-ray because people wanted to progress and felt unable to secure promotion without having to move to another modality such as CT or MRI. Staff told us that the trust was reluctant to offer higher bandings to staff and there were not always vacancies for people with enhanced practice skills to use those skills and therefore be paid at the higher grade.

The manager told us they could over recruit to ensure staffing numbers were maintained however retention of staff was a challenge.

Staff told us that radiographers tended to join the trust straight from university, stay for two to three years and then move to another trust at a higher grade.

The management team had met to discuss staff retention. They were considering ways to retain staff however were reluctant to increase staff grades in plain film x-ray without staff taking on additional roles, as some trusts nationwide had done.

The department employed some reporting radiographers who spent some of their time carrying out examinations and reporting on x-rays and other scans.
Staff in ultrasound had enhanced training and were able to interpret their own scans and carry out procedures.

**Sickness rates**
The trust had a sickness target of 4.7%. Within diagnostics, the trust had a low sickness rate for allied health professionals. Allied health professional and support staff sickness rate was approximately 2.4% at SGH. It was highest in the general radiology department at 9% and lowest in the ultrasound department.

**Bank and agency staff usage**
Information on bank and agency staff usage provided by the trust did not include allied health professional staff working in diagnostics and imaging.

We requested information about bank and agency use for AHPs. Between April 2017 and March 2018, 1435 shifts were covered by locum radiographers across both sites at a total cost of £512,368. These shifts were both day and night shifts, weekends and bank holidays at predominantly band six and band 7.

We spoke with the manager of the general radiology department. They told us they used four regular locums and offered overtime to all staff from all sites to cover vacant shifts.

Staff told us that if the department was at risk of being short staffed, radiographers could come from GDH to cover. Staff moved between SGH and GDH as needed to cover gaps in the rota. Both the manager and staff told us there was an induction process within the trust for all new staff and a local induction programme for new staff to the diagnostics department.

Staff never worked alone on the SGH site. There was always at least a radiographer and a health care assistant together at any one time.

**Medical staffing**
The trust reported their medical and dental staff numbers below, as of January 2018 and January 2017. No medical staff were reported at Goole District Hospital. This was because radiologists were based on one site but worked and reported across all sites as required.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>11.98</td>
<td>6.73</td>
<td>11.98</td>
<td>6.43</td>
</tr>
</tbody>
</table>

*relates to staff that had a location of ‘trust wide’ in the RPIR

Medical staffing rates at SGH were 56% in January 18, and 56% at Scunthorpe General Hospital. Staffing rates were marginally higher than the previous year at both sites however still very low.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

We requested the Radiology Benchmarking Dashboard Report of the trust. This was for the 2016/2017 outturn position. Of all the trusts who submitted data, this trust had the highest consultant radiologist vacancy rate.

The trust had significant problems recruiting radiologists despite actively trying to recruit both within the UK and internationally however visa regulations had hampered progress. The trust
continued to try to recruit as a continuous process.

The trust was working with local trusts’ medical schools and hoped to encourage registrar radiologists to come to the trust in training posts however at the time of the inspection this had not yet materialised.

At the time of the inspection, the department was outsourcing some of its routine and straightforward reporting to two external companies. If urgent advice or reporting was required out of hours, staff accessed one of the outsourced companies. However, a number of trust radiologists also had reporting stations at home and could read x-rays and scans from home if a report was needed urgently.

The trust told us that approximately 25% of CT and 16% of MRI scans were currently outsourced to other organisations for reporting at the time of our inspection.

The trust had an induction programme in place for new medical staff and there was a local induction programme within radiology.

**Vacancy rates**

For all staff in diagnostics and radiology

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>61.55</td>
<td>143.76</td>
<td>42.8%</td>
</tr>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>69.92</td>
<td>138.6</td>
<td>50.4%</td>
</tr>
<tr>
<td>Trust wide*</td>
<td>42.4</td>
<td>257.3</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

*relates to staff that had a location of ‘trust wide’ in the RPIR

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The trust was working with local trusts medical schools and hoped to encourage registrar radiologists to come to the trust in training posts however at the time of the inspection this had not yet materialised.

The trust was also hoping to offer CESR (certificate for eligibility for specialist registrar) posts to encourage medical staff to join the department.

**Turnover rates**

Turnover rates data provided by the trust do not include information on medical staff assigned to diagnostics.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Sickness rates data provided by the trust do not include medical staff working in diagnostics.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

The bank and locum staff usage within diagnostics across the trust is shown below: All medical staff worked across all trust sites.
Trust level

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0 (0%)</td>
<td>253 (94%)</td>
<td>15 (6%)</td>
<td>268</td>
</tr>
</tbody>
</table>

In diagnostics, from February 2017 to January 2018, a total of 253 shifts unfilled by substantive staff (94%) were filled by locum staff. There were 15 shifts (6%) that remained unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records

The department used electronic records and digital images accessible to all appropriate staff for viewing. Reports were available digitally and were part of the electronic patient record.

We looked at the record keeping system used in the department. It was linked to the patient’s main records and the Accident and Emergency department records system. The system made sure all relevant fields of information were completed and that results were easily accessible to relevant personnel.

Staff could check the A&E system to make sure any anomalies on x-rays or scans had been picked up by the medical staff in A&E who would look at the image before a reporting radiographer or radiologist would. This was particularly helpful when images were difficult to read, or anomalies were small. There was an additional system in place to ensure that once an image had been reported by the radiology team, the A&E department were notified of any potential missed diagnoses such as minor fractures.

X-ray results were emailed or posted to GPs automatically however the timeliness of this was dependent upon how quickly the x-ray or scan was reported. Reporting times were a KPI of the trust and were consistently monitored and reported upon.

Medicines

We checked the storage of medicines across the diagnostic and radiology departments at SGH. We found medication was stored safely and securely and was regularly checked to make sure no medicines were out of date. Medicines were stored above floor level in locked rooms with restricted access.

We spot checked some medicines and found these were all in date.

The scanning department used medicines such as contrast media for some patients. Staff were aware of the side effects and contra indications and carried out checks with patients to ensure their safety.

The department did not store or use controlled drugs.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a
never event. From March 2017 to February 2018, the trust reported no incidents classified as never events for diagnostics.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in diagnostics which met the reporting criteria set by NHS England from March 2017 to February 2018.

The incident was classified ‘Diagnostic incident including delay meeting SI criteria (including failure to act on test results) and occurred in September 2017. The incident took place at the SGH site.

(Source: Strategic Executive Information System (STEIS))

We spoke with staff about incidents. They could describe to us the process for reporting incidents electronically. They understood the type of occurrences they must report, relating to radioactive materials, public and patient safety and staff safety.

Some staff told us they should probably report more however, they didn’t because of time pressures.

Staff told us that if they reported an incident, they received an acknowledgement and sometimes feedback depending on the severity of the incident.

The diagnostics and radiology departments across the trust produced a regular newsletter where incidents, complaints and concerns were highlighted along with any changes to practice. The newsletter was also used as a method of communicating any external safety alerts to staff. These alerts were also emailed to staff and discussed at team meetings.

Staff understood the principles of duty of candour, being open and honest and told us that if they made a mistake, such as an incorrect x-ray, they would inform the patient and then report it as an incident. Duty of candour was used in diagnostic services across the trust, four times from February 2017 to January 2018. The information was not broken down by site.

**Is the service effective?**

**Evidence-based care and treatment**

The trust followed national and local guidance in the treatment of patients. For example, NICE (National institute of health and social care excellence) guidance for stroke patients.

Guidance was available on the intranet for all staff to refer to if they were unsure. Staff told us they followed best practice, guidelines, policies and procedures. However, due to lack of clinical audit we could not be fully assured that staff were following best practice and clinical guidelines.

Patients were given advice about action to take if their condition deteriorated and there were advice leaflets for patients about specific conditions and procedures. We looked at these and some needed to be reviewed.

Patients were protected from discrimination because appointments were allocated purely on clinical need.
Nutrition and hydration

The departments had water fountains available for patients to access cold water.

There were café facilities and shops selling food and drinks within the hospital which patients and relatives could access.

If staff had concerns about a patient who had not eaten and had a health condition such as diabetes, they could provide a light snack, however staff told us this almost never happened as patients usually came prepared.

Pain relief

The departments generally did not administer pain relief for patients. Patients brought to the department as inpatients or from A&E had usually received pain relief before being brought to the department.

Pain relief and sedation were available for patients, prescribed and administered by qualified staff in line with departmental policies and procedures. Staff told us they expected inpatients to have received most medicines on the ward and if a patient was unsettled and needed sedation, they would be returned to the ward to receive it.

Staff asked patients about their pain levels and tried to ensure any scanning was carried out in the least painful way.

Patient outcomes

We discussed discrepancy meetings with staff and the manager. They told us that discrepancies were discussed with staff and meetings held at least bimonthly in line with the Royal College of Radiologists guidance.

If there were particular concerns about the performance of individual staff, these were addressed by the manager with the individual.

The trust employed an ISAS (imaging services accreditation scheme) assessor however they were not currently in a position to apply for accreditation due to trust wide staff shortages and reporting delays. However, the trust was aware of the ISAS requirements and working towards them.

We asked the trust for evidence of ongoing clinical audit within diagnostic services. Evidence sent to us showed that the last clinical audit was undertaken in 2017/2018 and related to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Information sent to us after the inspection showed that some clinical audit was taking place in the department.

We requested the Radiology Benchmarking Dashboard Report of the trust. This was for the 2016/2017 outturn position. The report showed that the trust had fewer than the average CT scanners per 100,000 patients and fewer that the average MRI scanners per 100,000 patients. This corroborated what the trust was already aware of, that they needed more scanners to meet ever increasing demand.

Demand on the department had continued to grow in each modality other than PET scanning over the past five years and the trust had one of the highest levels of CT scans per 100,000 bed days in the country.

The trust had a rate of 2100 examinations per WTE staff. This was more than the average and
showed that staff at the trust were examining more patients than colleagues at other trusts.

Of the trusts who submitted data, this trust was seventh in the list of highest outsourcing trusts with 7% compared to an average of 4%. The highest trust had an outsourcing rate of 26%.

This trust could not meet the reporting demands of the examinations it carried out. There was an impact on patients because patients had to wait longer for the results of their scans and there was a risk that this could have a detrimental impact on their health, treatment and recovery.

**Competent staff**

**Appraisal rates**
From April 2017 to January 2018 85% of staff reported by the trust to be working in diagnostics at the trust had received an appraisal compared to a trust target of 95%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>53</td>
<td>66</td>
<td>80.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>40</td>
<td>52</td>
<td>76.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>30</td>
<td>47</td>
<td>63.8%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>154</strong></td>
<td><strong>199</strong></td>
<td><strong>77.4%</strong></td>
<td><strong>95.0%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

SGH had an appraisal completion rate of 77.4% which did not meet the trust’s target; however, medical staff were appraised within target. Other disciplines such as healthcare scientists and health professionals were much below the 95% target.

(Source: *Routine Provider Information Request (RPIR) P43 Appraisals*)

Staff we spoke with at SGH told us their managers scheduled appraisals with them however the evidence above shows that as of January 2018 there were still a number of staff who had not been appraised.
Staff said annual appraisals were supportive and worthwhile.

Staff told us that support for them in their day to day roles was very good both from their line managers and their colleagues.

Staff had received training in supporting patients with dementia and challenging behaviour and therefore patients with these conditions could be supported in the department. Staff told us they could ask for additional support if it was required.

The department at SGH used regular agency staff when needed and at the time of the inspection had four to cover vacancies and absences. These were regular staff from an agency who were familiar with the IT systems, procedures and policies of the department. However, there was a local induction in place to ensure staff were oriented with the department and familiar with where supplies and equipment were stored should a new locum come to the department.

Patients who attended the SGH departments could be quite unwell and all staff had undergone training to identify if patients were deteriorating and how to access further support for the patient if required.

**Multidisciplinary working**

The departments at SGH worked with the outpatient’s department and specialties to provide x-rays and scanning services for both inpatients and outpatients.

There were several multidisciplinary (MDT) clinics run across the SGH site and in conjunction with visiting consultants from other trusts. MDT clinics meant better care and treatment for patients as diagnostic tests were carried out and results available to clinicians on the same day.

Radiologists worked on site at SGH, however they could report on films from any location that had a reporting station.

Radiologist on site at SGH also carried out clinical interventions with patients using radiological guidance such as biopsies, injections and placement of stents. These interventions involved working with specialties and staff from other disciplines.

Radiologists attended multidisciplinary meetings about patients held on the other two sites. These meetings discussed patient diagnoses and treatment options with specialists such as surgeons and oncologists.

**Seven-day services**

The radiology departments at SGH had different opening hours. For example, Blue Sky was open from 7.30am to 10.30pm for CT and MRI with on call emergency CT scanning overnight however, there was no overnight MRI cover and patients needing an urgent MRI needed to be transferred to another trust as an ambulance emergency.

Ultrasound was open between 8.00am and 8.30pm Monday to Friday and 8.00am to 6.00pm at weekends. Plain film radiology was available 24 hours a day with on call cover over night for emergencies.

The department had a visiting CT scanner and a visiting MRI scanner on certain days during the week to assist with managing waiting times.

Images could be reported 24 hours a day and there was outsourced reporting cover in place from
5.00pm to 9.00am backed up by an on-call radiologist employed by the trust.

**Health Promotion**

The department had posters and leaflets to promote patient good health, such as about stopping smoking, healthy diet, child and adult safeguarding and domestic violence support.

We asked staff if they spoke with patients about promoting good health. They told us they would only intervene if the patient asked for advice or if they thought the patient was in immediate danger or harm.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff in the department had completed Mental Capacity training. The compliance rate was 87% therefore the trust target of 85% was being met at SGH.

Some staff were required to attend Deprivation of Liberty training. The compliance rate for this training was 100% across the trust.

We spoke with staff about obtaining consent form patients who had learning difficulties or were living with dementia. They told us if the patient was unable to identify themselves they would not perform the examination. We were unable to corroborate this as there were no such instances during our inspection. If the patient was an inpatient, and the patient could not give consent they told us they would expect to see information about a best interest decision. A best interest decision is a decision made on behalf of a patient by clinicians when the patients is unable to make that decision themselves.

The service at SGH provided plain film x-rays, ultrasound, CT, MRI and a number of invasive procedures such as biopsies. Some of these procedures required written consent from patients.

Staff involved in procedures where consent was needed told us consent was sometimes taken on the ward (if the patient was an inpatient) and sometimes in the department. Staff knew their responsibilities to explain procedures, possible side effects and complications during or as a result of a procedures and make sure the patient was able to understand and retain the information they were told before taking consent.

For plain film x-rays, verbal consent was obtained from patients. The process included staff informing patients of the risks of having an x-ray and the contraindication of x-raying when patients had some conditions or were pregnant.

When a patient was pregnant or suspected they were, staff discussed the risk of an x-ray on the unborn child and supported patients to make a decision. Staff also offered patients the option of lead apron protection of the abdomen in cases when an x-ray was necessary.

Inpatients who required an x-ray had their identity checked from their wrist band and against the x-ray referral. The staff did not formally document consent but used implied consent.

**Is the service caring?**

**Compassionate care**

We spoke with seven patients or their relatives during our inspection of the SGH radiology and
diagnostics sites.

All the patients we spoke with told us they had been treated with courtesy and respect. Patients told us they had their dignity preserved as they were treated and staff made sure they were covered and not left exposed. Patients were given privacy to undress and re-dress and asked if they needed any help (one elderly patient).

We observed staff interact with patients of different ages and with different health conditions such as dementia or hard of hearing. Staff were kind, patient and caring with patients as they supported them on and off beds, out of wheelchairs and on to scanning and x-ray apparatus.

All patients told us reception staff were courteous and professional and felt welcomed to the department.

**Emotional support**

Staff provided patients with emotional support during their attendance at the departments if it was needed in the form or reassurance and explanations.

Anxious patients were not rushed and were given time to get used to the environment. For example, patients worried about having a CT or MRI scan could visit the department prior to their appointment to look and the scanner and have staff explain exactly what would happen during the scan. Staff told us about a patient living with autism who was extremely anxious about their procedure because it involved holding their head tightly in one place. The patient visited the department regularly and each time, took an extra step in the process until they felt totally comfortable. Once this was achieved, the patient then had their scan.

Staff also supported patients with further advice and support and spent time with patients discussing procedures and diagnosis with patients.

Staff could refer patients for additional counselling and support if this was needed.

**Understanding and involvement of patients and those close to them**

The patients we spoke with told us staff explained to them why they were there and what would happen during the x-ray, scan or procedure they were having.

Patients and relatives said they were given time to absorb information and then ask questions about their treatment such as any side effects or complications they might experience.

Staff made sure relatives and carers could be with the patient if this was what the patient requested and if it was safe to do so, such as vulnerable patients undergoing x-rays.

Patients and relatives said staff explained information in a way that was easy to understand and did not contain lots of medical jargon or terminology. This made sure that when patients were being asked to give consent, they fully understood what they were consenting to and the associated risks.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The various diagnostic and imaging departments on the SGH site were all located on the ground floor of the hospital on a single storey with wide doors therefore it was easy for patients and
relatives to access. They were well signposted and patients told us they were easy to find.

Car parking on site was a difficult as there was a lot of demand for parking spaces.

There were some toys to keep children amused while they were waiting.

The general radiology department was open 24 hours a day however, overnight, service was limited to urgent and emergency activity. Staffing was reduced with two radiographers and a health care assistant on duty to treat patients.

The scanning department began scanning at 7.30am and finished scanning patients at 10.30pm seven days a week to try to meet demand. Emergency overnight CT scans were carried out by a team of on call radiographers with health care assistant support. Overnight MRI was not carried out on site and any patients needing an emergency MRI were emergency transferred to a neighbouring trust.

We asked staff about long waits in the departments. They told us that patients did sometimes have long waits, especially if another patient needed to be seen as an emergency. Although waiting lists were designed to allow some capacity for urgent and emergency appointments throughout the day, because of the unpredictability of emergency demand, there were times when routine patients experienced delays.

Staff told us they tried to keep patients informed of delays both when they checked in and throughout their wait if the situation changed however there were no delays at the times we carried out our inspection.

Meeting people’s individual needs

The trust provided information for patients about treatments offered by the radiology departments. These were also online for patients to access. We checked all the leaflets and found that seven had passed their review date. Additionally, there was no information about how to access the leaflets in other formats such as large print, Braille, easy read or other languages.

Staff told us they could access interpreters either in person or by telephone if needed.

The department could accommodate bariatric patients for x-rays if required and the waiting areas had some larger seats and sofas. Bariatric patients requiring some scans such as MRI or CT could not be accommodated on site and were referred to a different scanning provider with an open sided scanner.

Patients with claustrophobia or worries about scans could attend the department to look at the scanner and have the process explained to them before their appointment. The aim of this was to put the patient at ease but also to reduce the number of abandoned procedures. Patients who still felt they could not cope with being inside the scanner tunnel, or the noise of the scan could be offered an appointment to attend an open sided scanner or offered sedation at another appointment.

There were no specific quiet areas for patients with sensory needs or who did not like to be in busy areas due to health conditions in the general x-ray department however, we asked staff how they would support such patients and they told us patients would be supported to be seen quickly. There were no such patients in the department at the time of the inspection and therefore we were unable to see this in practice.

The Blue Sky suite had cubicles and side rooms and was a small department that at the times we visited was a quiet environment. Staff in this department also told us they would support patients to be seen quickly.
Access and flow

Diagnostic waiting times (percent waiting 6+ weeks)

From June 2017 to January 2018, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average, following an upward trend over the period. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England.

(Source: NHS England – Diagnostic Waits)

Patients had long waits to have their examinations reported upon. The trust had a backlog of reporting due to the shortage of radiologists in the department. At the time of our inspection, the backlog for each modality trust wide was as follows:

- Plain film x-rays, 1805 report backlog, longest report delayed by five weeks.
- CT, 551 report backlogs, longest report delayed by seven weeks.
- MRI, 353 report backlogs, longest report delayed by 10 weeks.
- Ultrasound, 12 report backlogs, longest report delayed by two days.

For general radiology there was a backlog of 1119 unreported films.

We discussed inpatient demand with managers in the trust. They told us that inpatient referrals were given priority, particularly from A&E, then the wards. Priority was then given to two-week urgent referrals, urgent referrals and then routine referrals.

We asked staff how scan referrals were prioritised. Staff told us decisions were made by administrative and radiography staff using specific criteria however radiologists were also consulted to make sure no urgent referrals were missed. This process was used across the trust.

The management team at SGH monitored performance against local and national key performance indicators (KPIs). We requested evidence of this and the trust provided us with the monthly report for each site and modality. The report was comprehensive and monitored waiting times, reporting times, staffing levels, locum and bank use, a financial summary, did not attend (DNA) rates, number of referrals, demand and activity increases and any exceptional events to
note. The report was discussed within the senior management team to ensure they were aware of any concerns or problems the department was encountering.

Managers told us that demand on radiological services was increasing significantly year on year leading to pressure on all radiology services although particularly MRI and CT.

When patients DNA, the department offered one further appointment, however DNA added pressure to services. The combined DNA rate for SGH was 1.7% for CT scans and 2.4% for MRI scans. Ultrasound DNA was 5.7% for non-obstetric scans.

There was a total of 1156 patients waiting up to six weeks for an ultrasound. In March 2018, however, ultrasound saw 80% of 31/62 day pathway patients within seven days.

In March 2018 SGH saw 76% of CT and 74% of 31/62 day wait MRI patients within 14 days.

The trust had encountered problems with mechanical breakdowns of both MRI and CT scanners and the risk register showed that some scanners were classed as ‘end of life’. This meant that the manufacturer no longer made spare parts. When the machinery broke down, new spare parts were not always available and the trust needed to use recycled spare parts that did not always have a long life either.

Over the six months from November 2017 to April 2018 the following breakdowns to scanners had occurred at SGH:

- CT, 538 slots and 211 hours of scanning time
- MRI, 90 slots and 43 hours of scanning time

Staff told us patients in the department sometimes had to wait because procedures were more complicated and sometimes needed preparation, such as injection of contrast media or other medication before they could have their scans. Although for inpatients, much of this was meant to happen on the wards, we saw examples of when this was not the case.

Within the general radiology department, some patients experienced delays if their attendance was unplanned. This had an impact on planned patients in the department. If there was a delay, staff told us they would inform patients how long this was likely to be either when then checked in, or if the situation changed.

**Learning from complaints and concerns**

From 7 February 2017 to 7 February 2018 there were nine complaints about diagnostics, all for radiology. The trust took an average of 55 working days to investigate and close these complaints.

The trust has a target to close complaints within 30 working days and a further target of 45 working days. Only two of the nine complaints in diagnostics were closed within 30 working days and with four closed within 45 working days.

The trust has a target to close more complex complaints within 60 working days. Five of the nine complaints (complex and non-complex) were closed within this target.

The most common subjects complained about in diagnostics services were patient care (five complaints), appointments (two complaints) and communications and admissions/discharges with one complaint each.

**Scunthorpe General Hospital**

There were three complaints about diagnostics at this site, taking an average of 29 days to close. The subjects of the three complaints were, communications, admissions and discharges and
appointments.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Summary of compliments

From 7 February 2017 to 7 February 2018 the trust received three compliments for diagnostics at SGH.

Scunthorpe General Hospital
There were three compliments for:

Radiology– three compliments received

There was information in the waiting rooms informing patient about how to make a complaint or pass on a compliment to staff in a formal way. Patients were encouraged to give feedback to improve the service provided.

Lessons learned were fed back to staff on a regular basis at team meetings and via a radiology newsletter that also contained information about incidents, new policies and procedures, changes and advances in practice and interesting information about the department trust-wide. Staff at SGH had to sign to say they had read and understood the newsletter contents. This was a trust wide practice.

Is the service well-led?

Leadership

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 clinical director and associate chief operating officer. Clinical support services also had a business manager and two business support managers.

Each modality also had a service manager who oversaw the day to day functions of their department. We met with most of these staff during our inspection. Modality managers were aware of the challenges facing their departments and the KPIs they were required to meet. They understood the challenges in relation to performance, demand, staffing and risks.

Staff we spoke with during the inspection at SGH told us that they felt well-led at a local level and they had no concerns with their line manager. They told us managers were approachable and supportive.

Most staff told us that their line managers recognised and appreciated their hard work although some expressed frustration about remuneration and recognition of their skills.

Staff we spoke with told us they knew who the new chief executive was and felt that the trust had changed in a positive way since our last inspection.

Vision and Strategy

We interviewed the management team during the inspection. They were aware of the pressures at SGH, the condition of the equipment, the staffing turnover and recruitment and retention issues and the increasing demand for more complex scans and interventions.
Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to try to manage demand however current resources in the department were increasingly stretched.

The management team had a strategy for diagnostic and radiology services. The team spoke about this at our last inspection in October 2016 however, progress with the strategy was not as advanced as the management team had planned it to be.

In October 2016 at our last inspection, the management team spoke about future proofing the departments across the trust, purchasing new and additional equipment, recruiting more staff and succession planning. However, at this inspection we found that these visions had not come to fruition with medical staffing shortages, increased demand on equipment and longer waiting and reporting times than at our previous inspection.

Whilst the management team were working to ensure that the service was sustainable for the future, there was a concerning, deteriorating picture from our last inspection to this inspection.

Staff were aware of the strategy for the diagnostic imaging departments across the trust and were aware of the delays. Staff told us they felt frustrated and concerned about how the trust would continue to function and provide services that met demand. One member of staff told us, “I do my best and hope for the best”.

**Culture**

We found there was good collaborative working between the staff teams at SGH and Goole District Hospital; however, these services did not link with the Grimsby site. The head of general radiology managed the Scunthorpe and Goole sites and staff from Scunthorpe sometimes worked at Goole to cover annual leave and sickness.

Staff we spoke with told us it was a “positive culture” with good teamwork. They said there were no problems escalating any concerns or worries at SGH.

We found there was good collaborative working between staff at SGH.

Staff we spoke with told us there was a “positive culture” with good teamwork within the different modalities on site.

Staff said there were no problems escalating any concerns or worries at SGH to line managers however, some staff felt that the more senior management team could be dismissive of their concerns. Some staff also felt as though the work they did was not always appreciated by senior leaders in the department and they were undervalued.

The team at SGH was often changing due to new staff joining and current staff leaving however staff told us the team worked well together and pulled together during difficult and pressured times to support each other. Newer staff told us that they felt supported by more experienced colleagues.

The departments were patient focussed and staff worked together to make sure patients had a good experience.

Staff spoke positively about the service they provided for patients and were aware of the importance of providing a quality service with a positive patient experience.

**Governance**
Governance arrangements were in place within radiology. The clinical support services (CSS) division held monthly meetings where performance and governance were discussed. Information from these meetings was shared with front line staff both in person and via email minutes.

The department held medical exposures committee meetings and radiation protection committee meetings. These were recorded and shared with relevant staff.

The service held monthly team briefing meetings at the SGH 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 at the team meetings. Comments, compliments, complaints, audits and quality improvement were also discussed. This information was also shared in a regular newsletter which was printed off and kept in the staff break room for staff to read at their convenience. All staff had to sign to say they had read the newsletter.

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 saw examples of this during the inspection as some radiographers showed us their feedback, mostly positive but with some constructive advice.

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.

There were governance processes in place to ensure that externally reported images were scrutinised and managers told us that they had sought assurance from each outsourcing support provider of their governance processes to ensure they were at least as robust as those of the trust. The trust was assured that there were robust governance processes in place.

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 a service level agreement was in place. The RPS was a radiographer based within the trust.

Management of risk, issues and performance

The hospital had a risk register in place and managers updated this accordingly. Managers were aware of the risks within their departments and were trying to manage them.

There were three risks on the risk register for SGH relating to radiology, diagnostics and imaging. One related to CT equipment not providing good quality scans leading to a risk of misdiagnosis. This was categorised as a high risk. The register recorded that a decision about replacement was with the trust board.

Two further risks related to general x-ray and were about a potential shortage of radiographers and aging equipment in some of the x-ray rooms. The risk register noted that recruitment was classified as a moderate risk. X-ray equipment replacement was classified as a low risk as replacement had commenced.

There were also risks in diagnostics and radiology that were classified as trust wide. There were five risks noted. Two were classified as high risk, two were classified as moderate risk and one was classified as low risk. One risk had not been classified. The risks related to workforce, meeting patient pathway targets and replacement of equipment.
Although the department was hiring equipment to meet additional demand, we still had concerns about scanning provision in an emergency if equipment broke down.

We had concerns that the trust had not completed a review of patients for assurance about the length of time some patients were waiting for test results and the potential impact on patient prognosis because of these waits.

Risks on the register had a clear owner and evidence of action and updates.

**Information Management**

The department collected information used to monitor and manage performance. There were measures in place to monitor and manage the performance of the department against local and national indicators. These were observed by the management team.

The department used several IT systems to collect and share information such as x-ray and scan results.

Staff could access patient information using an electronic system. This included information such as previous x-rays and scans.

Some information such as scan and x-ray reports were shared with GPs however this was done with the agreement of patients.

The trust had information governance policies and procedures in place to ensure that information was stored securely and protected patients’ privacy and security.

Staff were aware of their responsibilities in relation to data protection and making sure that information was accurate and managed securely. Data protection principles were followed within the department at SGH.

Information governance including data protection and confidentiality was monitored and any incidents reported appropriately.

**Public and Staff Engagement**

The trust did not supply us with any evidence to demonstrate engagement with patients who used the diagnostic and radiology services at SGH.

The trust had begun to work with staff across the staff to look at culture, engagement and equality and diversity across the trust. Staff at SGH were part of this engagement.

**Learning, continuous improvement and innovation**

Staff at SGH were unable to provide us with any examples of innovation in the department.

Staff told us they could access training that was related to their role however some staff felt frustrated at not being able to progress within the department and achieve promotion within plain film radiology. This was common across all three sites at the trust.
Diana Princess of Wales Hospital - Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments (ED) and other Urgent and Emergency Care services.

- Diana, Princess of Wales Hospital
- Scunthorpe General Hospital

Minor injuries unit at Goole Hospital provided services up to April 2018 when the provider changed.

(Source: Trust Routine Provider Information Request)

Activity and patient throughput.

Total number of urgent and emergency care attendances at Northern Lincolnshire and Goole NHS Foundation Trust compared to all acute trusts in England.

There were 151,765 attendances from April 2016 to March 2017 at Northern Lincolnshire and Goole NHS Foundation Trust as indicated in the chart above.

(Source: NHS England)
Urgent and Emergency Care attendances resulting in an admission.

The percentage of A&E attendances at this trust that resulted in an admission remained similar from 2015/16 to 2016/17 and was slightly lower than the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method.

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
Staff we spoke with told us that they were mostly up to date with their mandatory training. We spoke to three staff; they were aware of their non-compliance and their completion was discussed at their annual appraisal.

Some of the mandatory training was offered in routine meetings to encourage participation, for example mental capacity and equality and diversity training were completed at the medical staff’s quality and safety meeting. However, no medical staff from ED attended the meeting to receive the training.

Due to the low levels of registered sick children’s nurses (RSCN); three staff had completed a university accredited module course in paediatrics and all staff had completed paediatric intermediate life support (PILS). Twenty-three staff out of 42 had completed the European Paediatric Advance Life Support course (EPALS) which provided a more in-depth knowledge and skills for managing a critically ill child. The trust provided us with information that showed that Embrace had provided training to nine staff. Further training dates were booked for training from June to October 2018 where 50 staff were due to be trained. All staff had received training on PEWS and 57% on sepsis to ensure they were competent to support children within the department.

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses for staff in the emergency departments from February 2017 to January 2018 for medical staff by site is shown below:

### Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of medical staff trained (YTD)</th>
<th>Number of eligible medical staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>8</td>
<td>14</td>
<td>57.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>7</td>
<td>14</td>
<td>50.0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>6</td>
<td>14</td>
<td>42.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>6</td>
<td>14</td>
<td>42.9%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>5</td>
<td>14</td>
<td>35.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>4</td>
<td>14</td>
<td>28.6%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for medical staff in urgent and emergency care was 45.0% at trust level and 51.4% at Diana, Princess of Wales Hospital. This was significantly below the trust target of 85%. At site level, the trust target was not met in any mandatory training module.

A breakdown of compliance for mandatory courses February 2017 to January 2018 for qualified nursing staff by site is shown below:

### Diana, Princess of Wales Hospital
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of nursing staff trained (YTD)</th>
<th>Number of eligible nursing staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>40</td>
<td>43</td>
<td>93.0%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>39</td>
<td>43</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>36</td>
<td>43</td>
<td>83.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>34</td>
<td>43</td>
<td>79.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>31</td>
<td>43</td>
<td>72.1%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>30</td>
<td>43</td>
<td>69.8%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>27</td>
<td>42</td>
<td>64.3%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>26</td>
<td>41</td>
<td>63.4%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>22</td>
<td>43</td>
<td>51.2%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>18</td>
<td>43</td>
<td>41.9%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for nursing staff in urgent and emergency care was 72.4% at trust level and 71.0% at Diana, Princess of Wales Hospital. This was below the trust target of 85%. At site level, the trust target was met in two out of ten training modules at Diana, Princess of Wales Hospital.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

**Safeguarding**

Staff we spoke with were aware of how to report safeguarding concerns. Policies and procedures were in place for staff to follow. Safeguarding information and pathways were on display around the department for both patients and staff to view. We saw that staff responded appropriately to patients with safeguarding concerns. Staff provided us with examples of when they had referred to safeguarding to ensure patients were safe.

Safeguarding information was highlighted on both adult and children assessment documentation that was required to be completed. The department completed a dashboard monthly; this included auditing records to identify if safeguarding information was completed. We reviewed the record audits from January to May 2018 and found the majority of patients did not present with any safeguarding risk factors or concerns. In April 2018, the audit identified that within five records out of 150 a patient presented with a safeguarding concern. The audit identified that in all five records a safeguarding referral was completed.

We reviewed 11 sets of children’s assessments specifically looking to see if safeguarding information was documented. For ten patients there were no safeguarding concerns, one patient record identified concerns and that the patient was under other services; it was completed appropriately.

Systems were in place to alert staff to potential safeguarding risks. This included information within the computer system to highlight if there had been any previous safeguarding concerns.

We were told that the safeguarding team would attend the department and document within the patient’s record. The department collated information each day for children that attended up to the age of 17. The safeguarding team would attend the department from Monday to Friday to review the information collected.
The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses February 2017 to January 2018 for medical staff by site is shown below:

**Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of medical staff trained (YTD)</th>
<th>Number of eligible medical staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for medical staff in urgent and emergency care was 76.1% at trust level, 80.4% at Diana, Princess of Wales Hospital. This was below the trust target of 85%.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for nursing staff by site is shown below:

**Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of nursing staff trained (YTD)</th>
<th>Number of eligible nursing staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>39</td>
<td>43</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>39</td>
<td>43</td>
<td>90.7%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>36</td>
<td>43</td>
<td>83.7%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>30</td>
<td>43</td>
<td>69.8%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for nursing staff in urgent and emergency care was 77.6% at trust level, 83.7% at Diana, Princess of Wales Hospital. This was below the trust target of 85%.

**Cleanliness, infection control and hygiene**

Hand washing facilities were available around the department and signage to remind people of the importance of handwashing. Handwashing basins and hand wash gels were available at various locations. Sinks had taps that were non-touch to reduce the risk of cross infection. All cubicles and areas had access to personal protective equipment (PPE), dispensers, aprons and gloves.

We observed staff using appropriate (PPE) when completing clinical tasks. Staff complied with bare below the elbows policy and correct handwashing technique. Patients told us that staff were observed washing their hands.
The department was visibly clean, including toilet areas, cubicles and the children’s play area. We saw labels on equipment identifying if they had been cleaned and were ready to be used again. These contained both the date and time. We saw evidence that sinks and showers were flushed to reduce the risk of Legionnaire’s Disease. The shift lead would check that the task had been completed and document this.

At our inspection in November 2016, staff did not routinely carry out mattress audits. At this inspection there was evidence of mattress audits and staff acted on information found. We checked 10 mattresses in the department and found one with small tears in the mattress. We raised this with the department manager.

There were facilities available to quarantine patients that required isolation. One room was specifically designed for this and included a bathroom and toilet area. PPE could be accessed prior to entering the room.

There were cleaning schedules in place and we spoke to regular domestic staff that completed the cleaning in the department. They told us that the required tasks were completed in line with the schedules although there was no checklist to identify which cleaning had been undertaken. However, when we spoke to staff that routinely did the cleaning they were aware of what requirements were needed. Various mops and different coloured buckets were available and stored appropriately with colour coded posters visible.

Environment and equipment

There was a waiting area at the front of the department for patients to sit and wait to be seen. The area was also used for some patients that had been reviewed, treated and awaiting test results or discharge. The department used the NHS initiative ‘fit to sit’ which encouraged patients that were well enough to sit rather than lay on trolleys waiting to be seen. All chairs faced towards the reception area so staff could see any changes to patients sitting in the waiting area.

The department was separated into different areas for patients to be reviewed. These included minors, majors and resuscitation areas where patients could be seen dependant on their needs. The resuscitation area had four cubicles; one of these was fully equipped with all sizes of equipment for paediatric and neonatal patients.

A children’s waiting area was accessible for patients using ED in the paediatric assessment unit; this was on the same corridor as minors. The area was not monitored securely or gated off to prevent children leaving the area. There was a door next to the area that exited into the main hospital that children could potentially access. This part of the department would also close around 7pm therefore there would be no facilities for children after this time. This did not meet with the Intercollegiate Emergency Standards 2012. We saw that some children used this area along with the main waiting area at the front of the department. None of the cubicles areas were dedicated and designed specifically for children (with the exemption of the resuscitation area). This meant it did not meet the Intercollegiate Emergency Standards 2012 which identified that at least one clinical cubicule space for every 5,000 annual children attendances should be dedicated to children.

Ambulance patients were brought in through a separate entrance into an ambulance assessment area. Crews booked patients into the department and waited to hand patients over to the dedicated registered nurse within that area. The ambulance assessment area had space for up to four trolleys however if all the bays were full then patients would wait along one allocated corridor located next to the ambulance assessment area. This area included equipment to review the patient such as completing their observations.
There was a designated facility within the department where major incident equipment was stored. Immediate access to the facility was available and staff were aware of how to access it. Tents and specialist suits were available to be used for protective measure in the event of chemical, biological, radiological and nuclear (CBRN) hazards. A designated area was used outside in the event that a tent was required.

Resuscitation trolleys including paediatric and neonatal were in the department and labelled with an equipment list. We checked all the trolleys and found that they all contained the relevant equipment. Checklists were in place for staff to monitor that a review had taken place. We saw evidence that these daily checks had been completed.

There were appropriate stock levels of equipment and we saw that stock rotation was in place to ensure that it was used prior to the expiry date. We checked sharps bin and found these to be signed and dated and not overfilled.

We checked six pieces of different types of equipment, these included infusion pumps and blood pressure monitoring devices. All these were in good working order and five had been safety tested and checked according to manufacturer's recommendations. The one piece of equipment that had not been retested had been due to be completed in December 2017. We raised this with staff in the department.

Assessing and responding to patient risk

The median time from arrival to initial assessment was consistently worse than the overall England median from February 2017 to January 2018.

An improvement in the trust's performance was seen in October 2017 with a continued lower performance for the remaining reporting period. In the most recent period (January 2018) the trust reported a median initial time to assessment of 15 minutes compared to the England median of nine minutes.

**Ambulance – Time to initial assessment from February 2017 and January 2018 at Northern Lincolnshire and Goole NHS Foundation Trust.**

(Source: NHS Digital - A&E quality indicators)

A streaming process was in place where a registered nurse sat at the reception desk and streamed patients to the most appropriate place. The streaming nurse could refer patients to be seen more appropriately by the GP primary care service on site or directly into the majors department to be triaged and observations taken by the appropriate nurse. Patients were triaged using a recognised triage tool and could also be referred to the minor parts of the department to be reviewed by an emergency care practitioner.

Patients arriving by ambulance were brought into a separate area which contained spaces for up to four patients and triaged by a registered nurse allocated to the area. During our inspection we saw that the ambulance bays were full and several patients were waiting along the corridor.
waiting to be assessed. We were told that the corridor was often used and was set up with wipe boards to monitor times and NEWs scores. We saw that patients were regularly assessed and reviewed whilst waiting to be transferred into the ambulance bay area.

We reviewed 46 patient records that arrived by either ambulance or self-referred to identify when they had been triaged and initially seen. The number of patients that were seen within 15 mins was 54% (25 patients). The remaining 46% (21 patients) were seen over 15 mins with the majority seen within 30 minutes; one patient was triaged after one hour.

There was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Diana, Princess of Wales Hospital until July 2017. Performance improved during the remainder of the reporting period from 73% in July 2017 to 63% in February 2018.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Diana Princess of Wales Hospital.**

![Graph showing the number of journeys with turnaround times over 30 minutes from March 2017 to February 2018.](image)

**Ambulance: Percentage of journeys with turnaround times over 30 minutes – Diana, Princess of Wales Hospital**

![Graph showing the percentage of journeys with turnaround times over 30 minutes from March 2017 to February 2018.](image)

(Source: National Ambulance Information Group)

We spoke with several paramedics who attended the department regularly. They confirmed that the turnaround time had changed and improved since our last inspection. At that inspection patients were handed over to ED staff and then booked into the hospital at reception. If the crew had to wait more than 15 minutes, patients would be booked in after that time which would affect the waiting time as it was not recorded. At this inspection, the system had changed, patients were booked straight into ED by an electronic system on arrival to the department. This meant that the figures were a true reflection of the time they arrived and stayed within the department.
The department had a designated mental health assessment room (room five). The room was not solely used for this purpose and was equipped with general equipment which could be unattached and taken out of the room. Staff told us that all furnishings would be removed when patients with mental health conditions used the room. During our inspection we saw that the room was occupied by patients with and without mental health conditions. We saw that the moveable equipment had been removed as appropriate.

The designated room was not ligature free and included fixed metal coat hooks and a plastic leaflet rack that could not be removed. We raised this at the time of inspection and immediate action was taken to remove both of these items. The items had been incorrectly placed in the wrong room however staff were unaware and had not thought of these as risks when placing patients with mental health needs in the room. There was one set of double doors into the designated room; however, they did not open outwards when exiting the room. This meant staff could not exit the room quickly if required. The room also had another exit door that could be used. The room also had several points within the room that could be identified as a ligature risk; these included door handles and taps. The room did have a strip alarm around the walls that could be used within an emergency.

The designated room was not ligature free and included fixed metal coat hooks and a plastic leaflet rack that could not be removed. We raised this at the time of inspection and immediate action was taken to remove both of these items. The items had been incorrectly placed in the wrong room however staff were unaware and had not thought of these as risks when placing patients with mental health needs in the room. There was one set of double doors into the designated room; however, they did not open outwards when exiting the room. This meant staff could not exit the room quickly if required. The room also had another exit door that could be used. The room also had several points within the room that could be identified as a ligature risk; these included door handles and taps. The room did have a strip alarm around the walls that could be used within an emergency.

The room was located at the end of the corridor which would protect the patient’s privacy and dignity better than the other bays, however it was not in visual sight of any staff. Staff informed us that a patient at risk would never be alone in the designated mental health assessment room and family members, hospital staff would have to be present. If a patient was alone and not appropriate to be in the room, other cubicles across from the nursing and medical station would be used. We saw this area utilised for this purpose during our inspection and equipment removed. Security staff were used at times to ensure safety.

A mental health risk assessment was incorporated into a standard operating procedure (SOP) for the management of patients with mental health presentations within the emergency department. It contained a flow chart, risk assessment and a threshold assessment grid (TAG) which provided an overall TAG scoring for the patient. Staff would record in the SOP and gather information to formulate a risk score. The TAG score provided a clear indicator of the patient’s risks and the actions staff should take depending on the score. For example, if the patient was identified as a medium risk, 30 minute face to face observations should be completed and the patient should receive treatment in an identified assessment room or high visibility cubicle. However, the SOP does not allow for staff to write a detailed update of ongoing issues whilst in the department and actions taken for each level of risk. The information would be documented in the routine ED patient record. Within the SOP it allowed staff to reassess the level of risk and note any changes to the risk level.

Staff in the department used the mental health risk assessment SOP and could tell us how they would manage patients in the department with mental health needs. We reviewed the documents for the three patients in the department with mental health needs and found the relevant information had been completed. The department completed a dashboard monthly; this included auditing records to identify if mental health information was completed. For April and May 2018, it identified that nine patient records were reviewed that had attended the department with a mental health need. All nine patients had a mental risk assessment completed and were managed in the appropriate environment.

The mental health assessment room had guidance on the door for staff on the steps they should take if a patient with mental health concerns required the room. This included completion of the mental health risk assessment SOP and the removal of the equipment in the room.

The trust used a National Early Warning Score (NEWS) to measure whether a patient’s condition was improving, stable or deteriorating; this indicated when a patient may require a higher level of care. At our inspection in November 2016 we found that NEWS and paediatric early warning...
scores (PEWS) were not always recorded. At this inspection we found that an electronic NEWS score was in place and linked to the patient’s electronic record. The NEWS score would be highlighted on the screen and indicate when the next observations were due to be completed. We saw that when a patient’s observations were due this flashed on the screen to alert staff; a member of staff reviewed and completed the NEWS. The electronic system showed whether the NEWS score had increased, decreased or stayed the same.

The PEWS scoring had recently changed into separate age ranges to ensure that the physiological parameters within the various ages reflected the correct range. These forms were not accessible electronically.

We reviewed 48 records of the NEWS or PEWS score and found that 81% of records contained the relevant scores. The department completed a dashboard monthly; this included auditing records to identify if NEWS and PEWS was recorded. We reviewed the dashboard from January 2018 to May 2018 which identified that all records had NEWS scores completed and the score had been actioned with appropriate clinical responses.

There was no separate paediatric area for patients and they would be seen in the relevant clinical area dependant on their needs. A resuscitation bay for children was appropriately equipped for patients that required that level of care. From April 2017 to March 2018 there had been 12,160 paediatric attendances at the department. There were limited numbers of registered sick children’s nursing staff in the emergency department. Therefore, a paediatric support pathway was in place to ensure that staff knew who to contact for advice regarding children. The information was displayed around the department and staff knew who to contact. The pathway identified the process to follow for paediatrics for both major and minor injuries presenting at the department.

The children’s wards had open access for ED staff to contact them. A situation, background, assessment and recommendation (SBAR) form was completed by staff when contacting paediatric colleagues about patients. This allowed staff to document the care that the paediatric team wanted the ED team to follow and complete. Staff told us that they felt the process worked and they received support.

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From February 2017 to January 2018 the trust reported 1,014 black breaches at Diana, Princess of Wales Hospital.

There was a reduction in black breaches over time at Diana, Princess of Wales Hospital, with the highest numbers of black breaches reported from February 2017 to July 2017 (an average of 118 per month). Although the number of black breaches generally reduced from August 2017, higher numbers were reported in September 2017 (80 breaches) and January 2018 (73 breaches).

Diana, Princess of Wales Hospital

![Graph showing black breaches over time at Diana, Princess of Wales Hospital][1]

(Source: Acute Routine Information Provider Request (RPIR) AC11 Black breaches - emergency department)

We reviewed ED meetings and the number of black breaches were discussed. It identified in minutes of the weekly flow meeting in February 2018 that a meeting had been arranged to review the whole process to ensure all staff were clear and supported. From 19 December 2017 to 28 January 2018 there had been 66 breaches.

**Nurse staffing**

The trust reported their registered nursing staff numbers as below, for January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>105.6</td>
<td>106.6</td>
<td>107.2</td>
<td>102.1</td>
</tr>
</tbody>
</table>

The trust had a 1.7% over-establishment of nursing staff in urgent and emergency care in January 2018 with all sites reporting more nursing staff in place than were planned. For the previous year (January 2017) the trust had a nursing and midwifery staff fill rate of 92.7%.
Annual vacancy rates for nursing and midwifery staff in urgent emergency care from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE as at January 2018)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>-1.1</td>
<td>105.6</td>
<td>9.2%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 16.3% for nursing and midwifery staff in urgent and emergency care, which was above the trust’s target vacancy rate of 6.3%. This did not meet the trust’s target for vacancy rate.

Please note, while the figures for January 2018 show an over-establishment at all sites, the annual rate is calculated over the 12 month reporting period.

At the time of our inspection there were five vacancies for band five registered nurses. The department had increased the number of band six nurses; permanent staff had been appointed into these posts which had decreased the number of band five nurses available. The number of band two staff (carers) had been increased to provide personal care and care rounds to patients ensuring that their basic needs had been met.

The department had determined what number of nursing staff was required on each shift to maintain safety of patients. A required number of staff were planned to provide the correct cover for the department each day. This consisted of ten registered nurses during the day and eight registered nurses during the night. Two emergency nurse practitioners also worked within the minors department assessing and treating patient with minor injuries and illnesses. When the planned cover was not achievable, the shift leader would generate an indicator to identify the level of risk to the department. Senior managers and managers told us that it would be managed as a ‘red flag’ and escalated to be one of the areas that was required to be filled first with staff. This meant that it would be covered by bank, agency or staff from other areas.

During the day the ten registered nurses were allocated to specific roles and areas for the duration of their shift. This allowed staff to provide consistency throughout an ongoing period. On each shift there was a shift lead who would oversee the department, review patient status and report to the Trust’s safe staffing briefings the current situation within ED. Dedicated registered nurses were provided within the ambulance assessment area however, staff told us this area often did not have a healthcare assistant for the duration of a shift.

During our inspection we saw that the planned number of registered nurses was not always achieved during both the day and night shifts. We saw that eight registered nurses were available within the day with an increase to nine part way through the day. Only six registered nurses were available at night. The planned number of healthcare assistants were met and sometimes exceeded the actual requirements. However, during our inspection, we saw that one healthcare assistant was working across streaming, triage and the minors areas due to staff shortages.

We reviewed three weeks of nursing rotas and found that bank nurses covered vacancies or sickness on each shift. We spoke with agency staff during our inspection who confirmed that they worked regular shifts each week on the department.
Paediatric nurse staffing had reduced since our last inspection in November 2016. Previously there had been eight registered sick children’s nurses (RSCN). At the time of this inspection, there were only three RSCNs, with two more due to start. This meant that the Intercollegiate Emergency Standard 2012 to have sufficient RSCNs to provide one per shift was not met. The department manager told us that there was difficulty in retaining the specialist nurses and they were looking at alternative ways of retaining staff. This included a potential rotation with other paediatric areas such as the children’s wards. As there was no specific paediatric department, patients were seen by registered nurses allocated to certain areas. There was a play specialist that was dual trained and worked weekends and evenings to cover when the majority of children would attend. Staff in the department were aware of who to contact to support them with children related issues and felt they received support.

Nurse staffing was recorded and on display within the department for patients and the public to read. It highlighted on the board if the staffing levels were at an acceptable level. It documented that it was the responsibility of the shift leader to highlight staffing issues; these included reviewing with senior nurse, bed manager and whether the issue had been escalated to the bed manager. We found that the board was kept up to date during our inspection.

The trust was developing new roles such as nurse associates who would support the nursing team. The department were supported nursing associates and encouraging their own staff.

Annual turnover rates for nursing and midwifery staff in urgent emergency care from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>2.00</td>
<td>39.48</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 7.4% for nursing staff in urgent and emergency care, which was lower than the trust’s target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates for nursing staff in urgent emergency care from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>764.85</td>
<td>14,442.97</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 5.5% for nursing and midwifery staff in urgent and emergency care, which was higher than the trust’s target of 4.1%. This did not meet the trust target for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The nursing bank and agency staff usage by site is shown below:
Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0 (0.0%)</td>
<td>456 (54.1%)</td>
<td>186 (22.1%)</td>
<td>843</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>716 (24.8%)</td>
<td>765 (26.5%)</td>
<td>268 (9.3%)</td>
<td>2,890</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018 there were a total of 3,228 nursing shifts filled by bank or agency staff in urgent and emergency care across the trust, which represented 33.6% of all available shifts and 7.6% of all shifts, remained unfilled.

At Diana, Princess of Wales Hospital there was a total of 1,937 nursing shifts filled by bank or agency staff in urgent and emergency care, which represented 31.6% of all available shifts and 7.4% of all shifts, remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

The trust reported their medical staff numbers as below, for January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>54</td>
<td>61.2</td>
<td>54.8</td>
<td>63.5</td>
</tr>
</tbody>
</table>

The trust had a 12.7% over-establishment of medical staff in urgent and emergency care in January 2018.

New roles such as physician students and advanced care practitioners (ACP) had been created and commenced who would support the medical staff on completion of the courses. Work was ongoing to identify how they would fit into the medical rotas.

For consultant cover in the department the trust’s standard was for cover between 8am to 10pm Monday to Friday. On weekends consultant cover was from 8am to 2pm. Outside of these hours, consultants were on call. This did not meet the Royal College of Emergency Medicine guidance of consultant presence of 16 hours a day. Staff told us that consultants were readily accessible on call, willing to help and would attend the department when needed. Night time cover was provided by two middle grade and one junior doctor.

We reviewed the medical staffing and there were eight permanent consultants in post. This did not meet the RCEM medical staffing requirements that identified there should be a minimum of ten consultants per ED to ensure consultant cover in place from 8am to 10pm, seven days a week with some doubling up in the afternoon and weekends where demand is greater.

We looked at eight weeks of medical rotas from March 2018 to May 2018 to review the cover. Consultant cover up to 10pm was not always consistent and for 16 days within the eight weeks it was not recorded on the rota that a consultant was accessible until 10pm. Staff confirmed that cover up to 10pm was not consistent and sometimes not met. In May 2018 the weekend consultant cover had been structured to try to cover up to 6pm. A rota co-ordinator had been in place for approximately five weeks. Their role was to work with the medical staff to create a rota and fill in the gaps where medical staffing was not at the required levels. Staff told us that medical staff had offered to complete and cover vacancies with extra shifts.
As of December 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 29 whole time equivalent staff working in Urgent and Emergency Care at Northern Lincolnshire and Goole NHS Foundation Trust.**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>31%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>14%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>18%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The bank and agency staff usage from February 2017 to January 2018 is shown below, by site:

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>63</td>
<td>345</td>
<td>1</td>
<td>409</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>353</td>
<td>1,259</td>
<td>160</td>
<td>1,772</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>871</td>
<td>2,166</td>
<td>111</td>
<td>3,148</td>
</tr>
</tbody>
</table>

**Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42</td>
<td>343</td>
<td>0</td>
<td>385</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>178</td>
<td>907</td>
<td>89</td>
<td>1174</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>139</td>
<td>718</td>
<td>39</td>
<td>896</td>
</tr>
</tbody>
</table>

In urgent and emergency care, from February 2017 to January 2018, a total of 1,287 medical and dental shifts were filled by bank staff and 3,770 shifts were filled by locum staff. There were 272
shifts that remained unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

There was difficulty in recruiting to the middle grade medical positions; therefore, there were several vacancies at this level. Senior management offered permanent and fixed term contracts to staff. However, the majority of staff preferred to keep with a zero hours contract to provide them with the flexibility. The majority of middle grade staff were regular locum doctors. To attract more middle grade doctors the trust had introduced a local CESR (Certificate of Eligibility for Specialist Registration) programme to encourage new staff to apply to the trust and offer a route for progression. One staff member was on the course and others were due to start.

We looked at eight weeks of medical rotas from March 2018 to May 2018 to review the cover for middle grade doctors. Most shifts including nights had locum staff cover for middle grade doctors, sometimes both staff covering the night shift were both regular locums.

We looked at six weeks of medical rotas from March 2018 to April 2018 to review the cover for junior doctors. Locum cover for junior doctors was less required in March than April 2018 with 29 shifts covered in March over a two week period and 23 shifts over a four week period in April 2018.

The department saw under 16,000 children per year (12,160 seen over last year) and did not need a consultant with sub-specialist training in paediatric emergency medicine as required by RCEM. No consultants had paediatric sub-specialist training.

Annual vacancy rates for medical staff in urgent and emergency care from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE as at January 2018)</th>
<th>Total number of staff establishment (WTE as at January 2018)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>-7.2</td>
<td>54</td>
<td>41.4%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 38.2% for medical staff in urgent and emergency care, which was above the trust’s target vacancy rate of 6.3%. Both sites did not meet the trust’s target for vacancy rate.

Please note, while the figures for January 2018 show an over-establishment at two sites, the annual rate is calculated over the 12 month reporting period.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Annual turnover rates for medical staff in urgent emergency care from February 2017 to January 2018 are shown below.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>0.00</td>
<td>9.40</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 2.2% for medical staff in urgent and emergency care,
which was lower than the trust’s target of 9.4%. Both sites met the trust’s turnover target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates for medical staff in urgent and emergency care from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>23</td>
<td>3,431</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 0.7% for medical and dental staff in urgent and emergency care, which was lower than the trust’s target of 4.1%. Data was only provided for Diana, Princess of Wales Hospital.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Records
At our inspection in November 2016 we found that the quality of nursing records varied considerably and did not contain information regarding patient’s pressure area care, falls assessments or if they were offered any food or drinks. At this inspection we found that documentation had improved and appropriate assessments were recorded. Records had been reviewed and changed ensuring that more in depth information was recorded. Staff confirmed that records had changed and they were completing more documentation.

The ED nursing assessment document had a care round section which included a review of the patient’s needs over a two-hour period. This included asking the patient a series of questions such as; whether the patient needed the toilet, was the patient comfortable, offering the patient any food and drink. We reviewed 34 patient records where the patient should have a completed and ongoing care round documented and found that 31 had been recorded. The department completed a dashboard monthly; this included auditing records to identify if care rounds had been completed. We reviewed the dashboard from January 2018 to May 2018 and identified that 97% of patients had care rounds completed and 4% did not have anything recorded.

We reviewed 26 records where the patient should have a completed pressure ulcer assessment and found that 24 were recorded appropriately. The monthly dashboard also documented whether risk assessments were completed and whether appropriate care was given. The dashboard statistics identified that 98% of patients had completed assessments.

Medicines
At our last inspection in November 2016 we observed that the bag of medicines used by the streaming nurse was left unsecure and not routinely locked away. At this inspection we found that the process for administering medication had changed and medication was stored more appropriately in a locked cupboard.

Each staff had a set of electronic keys to access medicines; this provided an audit for which individuals had accessed medicines. We saw that one staff member did not have a working set of keys and used a colleague’s keys to access the medicines. This meant that there would be no accurate record of who was accessing medicines. We raised this with the department manager at the time of inspection who assured us that this would be rectified.

We found some issues with medicines that required refrigeration; some liquid medicines had no dates of when they were opened in both the main and resuscitation fridges. There were also some
loose foils of tablets that were not secured in a medicine box. There were loose insulin pens in the resuscitation fridge with no indication of why they were required. There was too much stock in the fridge, this meant that the airflow was restricted.

The fridges in the department were part of an electronic pilot system which alarmed to pharmacy. We saw evidence of fridge monitoring daily, however the maximum temperature was higher than it was required at 11.2 degrees from the beginning of May 2018. We were told by nursing staff that they had notified pharmacy but were not aware of an outcome. Staff were also not aware of the pilot in place regarding the electronic system. This meant that we were not assured that medicines were stored at the correct temperature.

We checked the controlled drug medicine book and found the majority of checks were completed accurately. We saw that there were four missing witness signatures in April 2018. There was also evidence of regular checks by the pharmacy team.

An audit was completed between November 2017 and January 2018 to review whether the allergy status was completed on the ED medicine card. The findings identified that 87% (26 out of 30 charts) had been completed. The trust had indicated that they needed to improve the percentage and had rated it with an amber score.

We observed nursing staff administer medicines and fluids to patients, ensuring that the correct patient identification was checked. We saw that staff also completed the appropriate checks against the prescription.

Medical gases were stored separately and appropriately. We also saw that potassium infusions were kept separate.

Incidents

Staff were encouraged to report issues and there was a culture of investigating incidents. Staff were confident in using the system and told us that they would receive feedback. Incidents were discussed at team meetings as well as safety huddles that occurred daily. Teaching sessions were completed in the department on a weekly basis, some of these would reflect on some of the incidents identified.

We were told of examples where practice and policies had changed as a result of incidents. Staff told us of an incident about a patient with mental health needs who was in a high observation room opposite the nurse’s station. The relevant TAG forms and appropriate steps had been completed however there remained learning from the incident that was cascaded to staff.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From March 2017 to February 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from March 2017 to February 2018.
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from February 2017 to February 2018 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Department policies were based on National Institute for Health and Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines. Up to date NICE guidance was displayed in the department for staff to review. Articles of interest were also available in the department for staff to review.

The trust participated in the national RCEM audits so it could benchmark its practice against other emergency departments. Information provided by the trust identified that they audited various pathways including those used from the RCEM. Action plans were in place to improve areas in the audit that were not at the required level.

A range of evidence based risk assessments and tools were used across the department. These included Situation, Background, Assessment, Recommendation (SBAR); a document that was used to facilitate, prompt and appropriate communication especially amongst doctors and nurses.
A number of clinical pathways were used to support staff in complying with all aspects of best practice guidance when treating patients. We found that four of these pathways had not been reviewed and were the same pathways that we identified required updating at our inspection in November 2016. These included community acquired pneumonia bundle, blood transfusion, recognition of strokes and rapid access chest pain referral. One of these had a review date of February 2015.

Patient Group Directions (PGD) were in place which allowed staff to administer medicines to patients without an individual prescription from a doctor. Staff were using the PGDs although there were not current up to date signatures for new staff starting within the department. The PGDs contained evidence based information however the majority were due to be reviewed in 2017 and had been extended to be reviewed in August 2018. This meant that they may not contain up to date relevant information.

Staff had sufficient access to other policies and procedures through the trust intranet. These were regularly reviewed. We reviewed four policies all were in date and referenced latest evidence base guidance.

**Nutrition and hydration**

At our inspection in November 2016 patients were not routinely offered food and drink and it was not recorded when they were. At this inspection we saw that patients were provided regularly with food and drink. We saw that meals were provided for patients that had been in the department for a period of time.

As part of the care rounds which healthcare assistants completed they reviewed whether a patient required any food and drink. This was recorded in the patient’s record and we saw evidence that these were completed. Healthcare assistant positions had increased in the department to give capacity for them to provide care to patients. We saw that they provided support to patients who were unable to manage independently.

Hydration stations had been introduced which were accessible for patients. There was a water fountain and vending machine accessible in the waiting area of the department. Small snacks were also available for patients in the department.

The department completed a dashboard monthly; this included auditing records to identify if food and drink were offered to patients where appropriate. We reviewed the audits from January to May 2018 and all patients had been offered food and drink.

In the CQC Emergency Department Survey, the trust scored 6.6 for the question ‘Were you able to get suitable food or drinks when you were in the emergency department’? This was about the same as other trusts.

*(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)*

**Pain relief**

At our inspection in November 2016 pain scores were not always recorded. At this inspection we reviewed 47 patient records and found that 74% (35 records) identified that a patient’s pain had been reviewed. In 12 records it had not been recorded if pain relief had been assessed.

Patients told us that they were asked about their pain on arrival to the department and given pain relief quickly. We saw that patients were provided with pain relief by either the streaming or triage nurse at their initial assessment. We reviewed 50 patient records and found that 16 records (32%) did not require any pain relief. From patients that did require pain relief, 29 records (85%) showed they received timely pain relief.
The department completed a dashboard monthly; this included auditing records to identify if pain scores and analgesia was recorded. We reviewed the audits from January to May 2018 and found that 99% of patients had their pain score completed and recorded. It identified that 95% of patients received timely pain relief. The dashboard looked at whether pain scores were reviewed; 83% had a pain score reviewed and 17% was not completed. The manager told us that they were aware that this required further improvement.

The department had access to a variety of medications used for pain management. Patient group directions (PGD) were used for various different pain medicines. This allowed patients to receive adequate pain relief on arrival to the department and awaiting further assessment by the medical team. Pain scoring tools were used for both adults and children. Different pain scales were used for children; adapted more appropriately for their age. For example, facial pain scales were used for smaller children.

A trust audit was completed between November 2017 and January 2018 to review the recording of pain relief. The audit monitored whether a pain score and initial assessment was completed. The findings showed that 97% of records (29 out of 30) identified that this had been completed. It also identified whether the pain assessment had been documented and acted upon accordingly. This showed that 80% of records (24 out of 30) had the documentation completed.

In the CQC Emergency Department Survey, the trust scored 5.2 for the question ‘How many minutes after you requested pain relief medication did it take before you got it’? This was about the same as other trusts.

The trust scored 7.2 for the question ‘Do you think the hospital staff did everything they could to help control your pain’? This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Patient outcomes

A selection of the RCEM audit action plans were on display to identify where they had improved and required further improving. The trust’s audit department would also complete audits and the results were displayed. The RCEM audits were discussed in the trust’s audit meetings. We observed action plans were in place to address findings and recommendations from the audits. Further audits were identified, the topics were confirmed and lead doctors chosen.

Evidence from the sepsis audit was on display in the department and this showed areas where there could be improvements and also what they did well. The sepsis screening was completed in the nursing documentation in only 56% of records potentially leading to missed flags on triage. When the red box had been completed the pathway was commenced in 78% of records. The audit identified whether patients received their antibiotics within one hour. From August 2017 to March 2018 there were four months which were 100% compliance, other months ranged between 75% in November 2017 and 90% in January 2018.

The streaming of patients was also audited following the streaming service standard operating procedure (SOP). The audit reviewed patients between December 2017 and January 2018. This identified that 93% (28 out of 30 patients) were seen and assessed within 15 minutes of arrival. The trust had rated this as green.

RCEM Audit: Moderate and Acute Severe Asthma 2016/17.

Diana, Princess of Wales Hospital

In the 2016/17 moderate and acute severe asthma report, Diana, Princess of Wales Hospital failed to meet any of the seven relevant standards.
However, the hospital was better than other hospitals (in the upper UK quartile) for the following three standards:

- **Standard 1a:** O2 should be given on arrival to maintain oxygen saturation of 94-98%. Hospital: 44.4%; UK: 19%.
- **Standard 2a:** Vital signs should be measured and recorded on arrival at the ED. Hospital: 40.7%; UK: 26%.
- **Standard 3:** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 48.2%; 25%.

The hospital was similar to other hospitals (between the upper and lower UK quartiles) for the remaining four standards:

- **Standard 4:** Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy. Hospital: 84.4%; UK: 77%.
- **Standard 5a:** If not already given before arrival to the ED, steroids should be given within one hour of arrival (acute severe). Hospital: 30.8%; UK: 19%.
- **Standard 5b:** If not already given before arrival to the ED, steroids should be given within four hours of arrival (moderate). Hospital: 39.0%; UK: 28%.
- **Standard 9:** Discharged patients should have oral prednisolone prescribed according to guidelines. Hospital: 56.3%; UK: 52%.

*(Source: Royal College of Emergency Medicine)*

**RCEM Audit: Consultant sign-off 2016/17.**

**Diana, Princess of Wales Hospital**

In the 2016/17 Consultant sign-off audit, Diana, Princess of Wales Hospital failed to meet any of the four relevant standards.

The hospital was worse than other hospitals (in the lower UK quartile) for the following three standards:

- **Standard 1 (developmental):** Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Hospital: 0.0%; UK: 11%.
- **Standard 2 (developmental):** Consultant reviewed – fever in children under 1 year of age. Hospital: 0.0%; UK: 8%.
- **Standard 4 (developmental):** Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 0.0%; UK: 10%.

The hospital’s result for the remaining standard was similar to other hospitals (between the upper and lower UK quartiles):

- **Standard 3 (fundamental):** Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Hospital: 24.0%; UK: 12%.

*(Source: Royal College of Emergency Medicine)*

**RCEM Audit: Severe sepsis and septic shock 2016/17.**

**Diana, Princess of Wales Hospital**

In the 2016/17 severe sepsis and septic shock audit, Diana, Princess of Wales Hospital failed to meet any of the eight relevant standards.
However, the hospital was better than other hospitals (in the upper UK quartile) for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 83.0%; UK: 64.6%.

The hospital’s results for the remaining seven metrics were similar to other hospitals (between the upper and lower UK quartiles):

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Hospital: 60.4%; UK: 69.1%.
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 21.4%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. Hospital: 45.3%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 34.0%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 43.1%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 34.0%; UK: 44.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 15.4%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

Information received from the trust following the inspection provided evidence that there had been identified problems in the data collection for the RCEM severe sepsis and septic shock 2016/17 audit. Therefore, the trust had undertaken their own re audit and this had shown improvements.


Diana, Princess of Wales Hospital

In the 2015/16 Vital signs in children audit, Diana, Princess of Wales Hospital failed to meet any of the five relevant standards.

However, the hospital was better than other hospitals (in the upper UK quartile) for one developmental standard:

- Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Hospital: 85.0%; England: 69.7%.

The hospital performed similar to other hospitals (between the upper and lower England quartiles) for the remaining four standards:

- Standard 1a (fundamental). All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Hospital: 43.0%; England: 37.6%.
- Standard 1b (developmental). All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of capillary refill time. Hospital: 11.0%; England: 22.5%.
- Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set.
Hospital: 5.0%; England: 4.4%.

- Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital: 80.0%; England: 73.2%.

(Source: Royal College of Emergency Medicine)


Diana, Princess of Wales Hospital
In the 2015/16 Procedural sedation in adult’s audit, Diana, Princess of Wales Hospital failed to meet any of the seven relevant standards.

However, the hospital was better than other hospitals (in the upper England quartile) for one fundamental standard, Hospital: 21.2%; England: 2.6%:

- Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  7a: Return to baseline level of consciousness.
  7b: Vital signs within normal limits for the patient.
  7c: Absence of respiratory compromise.
  7d: Absence of significant pain and discomfort.
  7e (developmental): Written advice on discharge for all patients.

The hospital performed worse than other hospitals (in the lower England quartile) for two fundamental standards and one developmental standard:

- Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Hospital: 16.0%; England: 51.8%.
- Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Hospital: 70.0%; England: 90.0%.
- Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  4a: A doctor as sedationist
  4b: A second doctor, ENP or ANP as procedurist
  4c: A nurse

Hospital: 8.0%; England: 40.8%.

The hospital’s results for the remaining three metrics were similar to other hospitals (between the upper and lower England quartiles):

- Standard 1 (fundamental): Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
  1a: ASA grading
  1b: Prediction of difficulty in airway management
  1c: Pre-procedural fasting status

Hospital: 2.0%; England: 7.6%.

- Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
  5a: Non-invasive blood pressure
  5b: Pulse oximetry
  5c: Capnography
5d: ECG

Hospital: 14.0%; England: 23.9%.

- Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Hospital: 30.0%; England: 41.0%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16.**

Diana, Princess of Wales Hospital

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit, Diana, Princess of Wales Hospital scored 2.0% for standard 2 (developmental): Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation. This was similar to the England median of 2.0% but failed to meet the national standard of 100%.

(Source: Royal College of Emergency Medicine)

**Unplanned re-attendance rate within 7 days.**

From February 2017 to January 2018, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5% and worse than the England average in 11 out of 12 months.

The trust’s unplanned re-attendance rate ranged from 8.0% to 10.0% compared to an England average range of 7.5% and 9.1%. In the most recent month (January 2018) the trust reported an unplanned re-attendance rate of 9.3% compared to an England average of 7.6%.

**Unplanned re-attendance rate within 7 days - Northern Lincolnshire and Goole NHS Foundation Trust.**

(Source: NHS Digital - A&E quality)
Competent staff

New staff accessed a one-week induction called ‘care camp’ which identified objectives and expectations required by both the staff and trust. New starters to the trust told us they felt supported and completed competency packages for certain skills and procedures. There was a time period for staff to complete the packages and staff felt supported in completing them. Competency training would be followed up by the clinical lead that assessed the staff’s competencies. Staff told us that they were observed and signed off to say that they had met the certain requirements needed.

We spoke with new starters who told us that they had received some supernumerary time to develop and learn their role. Some staff did identify that they found it difficult to access training whilst at work and that some would be completed in the staff’s own time when the courses were not mandatory.

The department manager told us that there were core competencies for paediatric skills that were required to be completed as part of their training. Out of six emergency nurse practitioners (ENP) that worked with the minors department, none had completed any further training in paediatrics or were dual trained. The majority of children that attended ED would be seen in the minors part of the department. This meant that children would be seen by staff who had not received any additional specialised training in children’s conditions.

Teaching sessions were offered in the department weekly and were attended by both medical and nursing staff. We saw a teaching session led by a consultant taking place which reviewed different types of back pain that patients had been attending the department with.

Bank and agency staff would receive an induction on their first time working within the department. We spoke with bank and agency staff who confirmed this. The manager told us that agency staff would require certain level of skills to work within the department and this would be agreed with the agency prior to booking.

The band six staff rotated their responsibilities and would complete different roles. These included shift lead, streaming nurse, co-ordinator and clinical role when on duty whereas before they would work as the co-ordinator all the time. Staff told us that the variety in the role had decreased stress levels and increased their clinical skills.

From April 2017 to January 2018, 65.9% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 95%.

A split by staff group can be seen in the graph below:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff - Hospital</td>
<td>10</td>
<td>9</td>
<td>95%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>14</td>
<td>11</td>
<td>95%</td>
<td>78.6%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>16</td>
<td>9</td>
<td>95%</td>
<td>56.3%</td>
</tr>
<tr>
<td>Qualified Nursing Staff</td>
<td>41</td>
<td>23</td>
<td>95%</td>
<td>56.1%</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital had a 64.2% appraisal completion rate overall for urgent and emergency care with no staff group meeting the 95% appraisal completion target.
Multidisciplinary working

We observed good working relationships between nursing and medical staff in the department. Various meetings took place daily to aid communication between the different disciplines. These included two hourly board rounds, safety huddles and operational meetings. The safety huddle monitored the capacity within the department, discussed patients and any that had been there for a long period of time. Staff allocation was reviewed to ensure staff knew their roles and responsibilities for the shift.

We attended a safety huddle and a quality and safety meeting. This consisted of members of the medical and nursing staff coming together for a quick brief session. Incidents were discussed at the meetings and examples of how to reduce the risk of incidents reoccurring. The meeting was led by the ward manager and consultant. Staff told us that these meetings took place daily and felt they were effective.

Board rounds were completed every two hours. We observed part of a board round which was co-ordinated and led by one of the consultants. They discussed the patients in the department including their ongoing plan of care, waiting times and any referrals they were waiting for. Inappropriate referrals were discussed and a pilot was being completed in reviewing how many were received in the department and how they intended to reduce them.

At the time of our inspection the hospital was at operational pressure escalation level (OPEL) three, we saw various different disciplines attend the department to support the flow of patients. We saw that pharmacy, discharge co-ordinators, physio attended to identify if they could review any patient and turn them around.

There was a very good working relationship between the department and the mental health provider. Staff told us that they received excellent responses from the psychiatric liaison team.

There was a hospital discharge team within the hospital that consisted of social workers, nurses and continuing healthcare staff. The team met daily and reviewed any potential patients that may be discharged. They visited the department as part of their round and could access intermediate care to assist with discharges. There was no frail elderly assessment team (FEAST) currently in place at the hospital which could reduce the amount of time frail patients may need to spend in hospital. The trust did have a FEAST team in place at Scunthorpe General Hospital and was trying to replicate it at this hospital.

Staff would handover patients when transferring them to the ward. They would ring the ward and ensure that the bed was available and then transfer the patient. We observed a patient handover to the acute medical unit (AMU) where the handover was completed once on the ward.

Seven-day services

The emergency department was open 24 hours a day, every day for everyone who attended. There was access to other specialities to treat patients appropriately. Diagnostic services were readily available 24 hours a day for x-ray or pathology testing.

CT scan facilities were accessible and located close to the department. A new CT scanner had been installed which had significantly improved the service as the previous scanner regularly broke down. This had caused issues within ED as previously patients often had to be transferred to other hospitals to get the scan performed. A mobile scanner was in place to mitigate the issues. Since the new scanner had been installed there had been no incidents of it breaking down.
There was 24-hour access to adult mental health teams. Staff were aware of how to contact the teams and staff said they responded quickly to patients.

**Health promotion**

National priorities to improve the population’s health were supported such as smoking cessation and alcohol dependency. Health and condition specific advice was provided in leaflets and posters throughout the department and on the trust’s website. These included; how to manage your mood with long term conditions and managing with fractures.

Staff provided advice to patients and families regarding health promotion and access to services. Other agencies attended the department such as social workers and physiotherapists to support the patient to be more independent on their discharge.

Discharge advice was given to patients / carers to allow patients to safely manage their condition at home or where to seek advice if appropriate.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

There were trust wide policies in place for consent, mental capacity and deprivation of liberty safeguards (DoLS) which were accessible to staff on the intranet. There was an information board regarding patient’s mental capacity and Mental Capacity Act (MCA) guidelines and examples of when the assessment forms could be completed.

Not all nursing staff could describe the mental capacity process; they identified that the medical staff would complete and review a patient’s mental capacity. We reviewed records to identify if mental capacity information was assessed and recorded. Out of 21 records, 15 had completed information about mental capacity; this included all the patients who were in the department due to a mental health issue. We found six records did not contain information about a patient’s capacity. This included two patients who were living with dementia where their mental capacity might have been affected.

Patients told us that staff asked for verbal consent prior to completing any care and procedures. We observed that staff would gain consent and discuss with the patient whilst completing the care.

**Is the service caring?**

**Compassionate care**

Patients were observed to be treated with privacy and dignity. Curtains and doors were closed when patients were receiving care and treatment. We observed a number of interactions with staff and found them to always be cheerful, respectful and professional in their approach.

We spoke with 14 patients and relatives in all areas of the department; they all commented that overall, they received good care from staff. Patients felt respected and commented that staff introduced themselves and were approachable. At times in the department, some patients had to wait for a period of time; the majority of patients said staff were apologetic and tried to find appropriate areas for them wait.

Staff responded compassionately to patient’s pain, discomfort, and emotional distress in a timely and appropriate way. Confidentiality was respected in staff discussions about people and those close to them. We heard staff discussing patients and their current treatment and ongoing care; this was done with compassion and sensitivity.
In relation to patients who attended with mental health conditions we observed staff demonstrating a non-judgemental attitude towards patients. They described assessing patients’ needs on an individual basis which would include both mental and physical health. Staff members discussed building a rapport with the patient to try to de-escalate the situation and to provide reassurances.

The trust’s urgent and emergency care Friends and Family Test (FFT) performance (% recommended) was consistently worse than the England average from January 2017 to December 2017.

The trust’s FFT score improved over the reporting period with 83.4% of patients recommending the trust in December 2017 compared to the England average of 85.5%.

A&E Friends and Family Test Performance - Northern Lincolnshire and Goole NHS Foundation Trust

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided patients and relatives with emotional support. We saw that staff reassured patients and tried to put them at ease. A patient’s relative became unwell themselves during our inspection and we saw that staff supported the individual with their own needs.

Patient’s families were supported after bereavement. There was a quiet room for relatives to use if needed with access to a telephone and drinks. Chaplaincy services were available for multiple faiths. We saw that bereavement boxes could be provided for children where family members could store items.

Understanding and involvement of patients and those close to them

Patients told us they felt involved in planning their care, making choices and informed decisions about their care and treatment. We observed staff communicating in a way that people could understand which was appropriate and respectful. For example, we saw staff speaking to a child about their condition along with their parents.

We observed staff providing care to patients on arrival to the department. Patients were involved during the streaming and triage process and staff ensured that they understood information.

Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for. We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.
The department completed a dashboard monthly; this included auditing records to identify if patients were kept informed. We reviewed the audits from January to May 2018 and found that it identified all patients were kept informed.

We saw that staff discussed decision making with the patients and relatives. In times where, emergency care was required to be given, staff explained the decisions needed with either the patients or their relatives. The information was given in a way that people could understand and without using complicated medical terminology.

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.3</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem</td>
<td>8.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse</td>
<td>7.9</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses</td>
<td>8.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td>examining and treating you?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't</td>
<td>9.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td>weren't there?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a</td>
<td>8.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td>doctor, did they have enough opportunity to do so?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information</td>
<td>8.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td>about your condition or treatment was given to you?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical</td>
<td>8.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td>or nursing staff to help you?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and</td>
<td>8.9</td>
<td>About the same as other</td>
</tr>
<tr>
<td>another will say something quite different. Did this happen to you in</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>7.8</td>
<td>About the same as other</td>
</tr>
<tr>
<td>your care and treatment?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity</td>
<td>9.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td>while you were in the emergency department?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment,</td>
<td>6.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td>did a doctor or nurse discuss them with you?</td>
<td></td>
<td>trusts</td>
</tr>
</tbody>
</table>
| Q24. If you were feeling distressed while you were in                     | 6.0        | About the
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>the emergency department, did a member of staff help to reassure you?</td>
<td></td>
<td>same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q72. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>4.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people

Planning for service delivery was made in conjunction with a number of other external providers and commissioners to meet the needs of local people. For example, the trust worked with external partners to provide better access to primary care services via a GP service at the front of the department where appropriate patients could be referred to avoid attending ED. The trust had also worked with the ambulance providers to review the process and receive feedback of crews attending the department.

Due to the geographical area, both the hospital sites were aligned to different clinical commissioning groups (CCG). Staff told us they worked with their local CCG in how best to manage the needs of the local population.

We saw that the department manager was engaging with vulnerable groups to identify why they might not choose to attend the department and what could be improved. The department had
worked with the mental health provider to incorporate a standard operating procedure for patients with mental health needs attending the department.

Senior managers were reviewing the medical model required in the hospital to ensure that patient demand was met due to the increasing numbers of patients attending the department.

**Meeting people’s individual needs**

There was an electronic system that was used to alert staff of any individual needs that a patient may have. For example, an alert could be added to the system for a patient who had learning disabilities or was living with dementia. A more detailed dementia assessment screening would take place on the ward where they would be admitted to. Staff told us that patients who were living with dementia were transferred to cubicles with high visibility so staff could observe them.

The department had distraction aids for patients who were living with dementia and learning disabilities. These contained items that could be used to help occupy patients and would help to ease any anxiety.

There were specialist services available for staff to access and attend the department, these included learning disability, diabetic and dementia link nurses. Contact details were available throughout the department and included who to contact out of hours. There was also clear signage around the department with contact details for the mental health liaison team.

We were told of occasions where patients with learning disabilities may attend regularly due to their medical condition and their carers stayed with them. At times the carers completed certain aspects of the patient’s regular care routine. This helped the patient to remain comfortable and relaxed as they had a relationship with the individual.

The waiting room was able to accommodate wheelchairs and mobility aids and there were dedicated disabled toilets available. Baby changing facilities were also available. There were facilities, such as chairs and wheelchairs that could be used for bariatric patients and some trolleys could carry up to 250kg.

Patients had access to interpreting and translation services. These could be either face to face or by telephone. We did not see any patients that required the use of a translating service however staff told us they had used the service when required.

A range of information leaflets were available in the paediatric department to support children with minor illnesses.

There was an appropriate area that was used to allow relatives to see the patient if they had died in the department. This provided a private environment for relatives to wait or for staff to have sensitive conversations with them when needed.

The trust scored about the same as other trusts for the following Emergency Department Survey questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
**Access and flow**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust failed to meet the standard in any of the 12 months from February 2017 to January 2018.

From February 2017 to January 2018 the trust performed worse than the England average in eight out of the 12 months. The trust’s performance improved over time with the percentage of patients admitted, transferred or discharged within four hours being higher than the England average from October 2017 to January 2018.

**Four-hour target performance - Northern Lincolnshire and Goole NHS Foundation Trust.**

![Graph showing four-hour target performance]

(Source: NHS England - A&E waiting times)

We reviewed 49 patient records and found that 71% (35 patients) were not admitted, transferred or discharged within four hours of arrival in the ED. We saw that 29% (14 patients) did meet the national standard of four hours.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for five out of the 12 reported months from February 2017 to January 2018.

Performance against this standard showed a trend of improvement with the trust reporting a median time from arrival to treatment of less than 60 minutes for the most recent four months (October 2017 to January 2018). In the most recently reported month the trust has a median time to treatment of 59 minutes compared to an England average of 57 minutes.

**Ambulance – Time to treatment from February 2017 to January 2018 at Northern Lincolnshire and Goole NHS Foundation Trust.**
We reviewed 46 records for the time from arrival to treatment. In 11 records they were seen within one hour, with seven of them seen within 30 minutes. A further 16 patients were seen within two hours. Twelve patients were seen between two and four hours. In three records the time was not documented therefore it was difficult to ascertain the time they were seen. Two patients left prior to receiving a medical assessment.

The trust had an escalation and surge policy in place which provided a set of arrangements and guidance when normal operating functions were challenged. An activity, staffing and hazard (ASH) matrix was completed to identify how long patients had been waiting in the department and who it was required to be escalated to. For example, when patients had to wait in the department for more than six hours it would be escalated to on-call senior managers and to directors when this increased to eight hours.

The senior management team observed flow within the hospital and meetings took place several times a day to understand the bed situation, enable planning for expected admissions and discharges, and to ensure patient flow throughout the hospital was timely. The shift lead from ED would attend the meeting and report the findings of the current situation. These included the number of patients in the department, waiting time, current performance and the amount of four-hour breaches. We saw that the shift lead attended the meetings with the completed information and ASH matrix.

GP streaming was in place Monday to Friday between 8am and 8.30 pm. Some patients would be triaged by the nurse to be more appropriately seen by the GP within the department. However, there were times when there was no GP cover or they would refer patients back to ED due to their lack of experience. This meant that patients would be seen in inappropriate places and would impact on the number of patients in ED. Staff told us that there were several times there would be no cover or staff left the department before 8.30pm. This was discussed in meetings by ED staff to see how the process could improve. ENPs could refer directly to GP primary streaming, however the referral process required to speak to a doctor prior to accepting the referral was lengthy and time consuming. This was documented with team meetings regarding the referral process.

Staff felt that the streaming of patients at the point of entering the department had improved patient flow through the department. Staff felt they had coped better over the winter period. Escalation beds had been allocated on the department however these were not needed to be used over winter.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted.**

From February 2017 to January 2018, Northern Lincolnshire and Goole NHS Foundation Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average for six out of the 12 months. The trust’s performance improved over time with the trust reporting a lower percentage than the England average from August 2017 to January 2018.
Percentage of patients waiting more than four hours from the decision to admit until being admitted - Northern Lincolnshire and Goole NHS Foundation Trust.

(Source: NHS England - A&E waiting times)

Within the escalation policy there was a hospital emergency care standard that was required to be adhered to. This included ‘10 steps to improving the emergency care pathway’. However, this was not always followed. For example, it identified that speciality doctors must have arrangements in place to review patients within 30 minutes of the referral from ED. If the requirement could not be achieved the ED consultant on duty or on call had the authority to admit the patient to the appropriate speciality ward. We were told that speciality doctors would not always attend within 30 minutes and would not always accept the patient that the ED consultant admitted to the speciality ward. We reviewed weekly ED flow meeting minutes and saw in February 2018 that surgical doctors were refusing to accept patients until there was a vacant bed for them.

Patients were seen to be waiting in the department for beds in other areas of the hospital. The longest time a patient had been waiting for a bed was almost ten hours. We reviewed eight patient records that had been in the department for a long period; this showed assessments for pressure area care and nutrition. Four patients had been transferred onto beds within the department to ensure appropriate care could be given.

Number of patients waiting more than 12 hours from the decision to admit until being admitted.

Over the 12 months from February 2017 and January 2018, one patient waited more than 12 hours from the decision to admit until being admitted.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients over four hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-17</td>
<td>749</td>
<td>1</td>
</tr>
<tr>
<td>Mar-17</td>
<td>465</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>651</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>351</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>405</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>356</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>140</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>262</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>147</td>
<td>0</td>
</tr>
</tbody>
</table>
We saw that some patients were admitted to the diagnostic and discharge lounge from ED for a period of time whilst waiting for a vacant bed on their allocated ward. Since February 2018, 12 patients were admitted to the lounge for various amounts of time; the longest time being for eight and half hours.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment.**

From February 2017 to January 2018 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was generally better than the England average.

The trust’s performance improved over time with 3.1% of patients leaving the trust before being seen in February 2017 compared to 0% in December 2017 and January 2018.

**Percentage of patient that left the trust without being seen - Northern Lincolnshire and Goole NHS Foundation Trust.**

![Graph showing percentage of patients leaving the trust without being seen over time]

(Source: Source: NHS Digital - A&E quality indicators)

During our inspection we saw that some patients did leave the department prior to receiving an initial assessment by the medical team however they had received an assessment from either the streaming or triage nurse. We looked at four records to identify how they had been coded on the computer system. These were all coded differently although none of them had seen a doctor. This meant there was no consistency in reporting figures of patients that had not been seen.

**Median total time in A&E per patient (all patients).**

From February 2017 to September 2017 the trust’s monthly median total time in A&E for all patients was generally similar to the England average. The trust reported an improved performance from October 2017 to January 2018 with a lower median total time in A&E than the England average.

In January 2018 the median total time in A&E was 146 minutes which was lower than the
England average of 153 minutes.

**Median total time in A&E per patient - Northern Lincolnshire and Goole NHS Foundation Trust.**

![Graph showing median total time in A&E per patient for Northern Lincolnshire and Goole NHS Foundation Trust compared to England average.](image)

(Source: NHS Digital - A&E quality indicators)

**Learning from complaints and concerns**

The trust had a complaints policy which was located on the intranet for staff to access if needed. The department had a complaints response process that addressed both formal and informal complaints, which were raised through the Patient Advice and Liaison Service (PALS).

We spoke with staff who could tell us about the complaints process and how they would manage a complaint. Staff told us about some complaints and lessons learnt from these. The learning from the complaint was shared within the team through various methods.

The department manager told us that many of the complaints were due to patients not being seen in a timely manner. They felt that the number of complaints had reduced since the introduction of the streaming nurse and increasing the number of healthcare assistants to provide personal care. The trust was working in partnership with the GP service to create an information leaflet to advise patients of their experience and why they may be referred elsewhere rather than staying in the department.

From 7 February 2017 to 7 February 2018 there were 55 complaints about urgent and emergency care services at Diana, Princess of Wales Hospital.

The trust took an average of 50 working days to investigate and close complaints. The trust has three targets for closing complaints. The trust has a target to close complaints within 30 working days and a further target of 45 working days. Only 30% of all closed complaints in urgent and emergency care were closed in 30 working days and 50% of closed complaints were closed within 45 working days.

The trust has a target to close more complex complaints within 60 working days. Of all closed complaints (complex and non-complex) 80% were closed within this target.

The most complained about subjects at this hospital for urgent and emergency care services were:
• Patient care – 33 complaints (60.0%)
• Staff values and behaviour – six complaints (10.9%)
• Access to treatment or drugs – six complaints (10.9%)
• Communication – three complaints (5.5%)

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

The emergency department was part of the directorate of medicine. The triumvirate included an associate chief operating officer, divisional clinical director and associate chief nurse. The associate chief nurse had changed since our last inspection in November 2016. The directorate was split into three groups and ED was in the acute group along with medical areas such as: assessment medical unit, short stay ward, ambulatory care service and care of the elderly wards.

At our inspection in November 2016 we issued the trust with a Section 29A warning notice which stated that the quality of health care provided by the trust required significant improvement. We had significant concerns relating to staffing shortages, lack of escalation, lack of patient assessments and insufficient management oversight within the emergency department. We undertook an unannounced inspection in June 2017 where we found there still remained some significant concerns regarding the issues raised. At this inspection we found that there had been improvements in the areas of concern raised.

The senior management team acknowledged that further improvements were required in ED and the warning notice had provided them with a focus on where to improve. They told us that they felt supported by management through the hospital to address the issues in ED. The escalation and surge policy and activity, staffing and hazard (ASH) matrix provided evidence of the current demand in ED. It allowed the hospital to respond when the demand in ED was high and staff were brought into the department to help with the access and flow of patients. Staff also told us that they felt supported by these new processes in place and felt the hospital worked together. During our inspection we saw that the department was under extreme pressure and the ASH matrix reflected the concerns. We saw that staff from other departments came to ED to provide support to both patients and staff.

The department had increased the number of band six nurses from five to ten. This allowed for one band six to take on the role of shift lead. The shift lead’s responsibilities included completing a clinical walk round every two hours to review the care and needs of the patients. The shift lead would provide input into the two hourly board rounds and complete information into the activity, staffing and hazard (ASH) matrix to feed into the operation meetings to inform the trust of the level of activity and issues within the department.

The senior leadership team on the department consisted of a medical clinical lead, department and operations manager. The leadership team were visible on the department with the manager and medical clinical lead providing clinical care to patients in the department. Staff told us that the senior leadership team provided support and they could raise concerns with them. We saw that the team worked well together and would discuss issues and concerns together. Staff spoke highly of the department manager and felt they provided them with support and direction.

Vision and strategy
The team had a vision and were striving to improve on standards. The ethos of the department and the wider hospital had changed in that when the department was under extreme pressures other departments around the hospital would provide additional support.

We spoke with the senior management team and they were aware that further developments were still required to improve the services, such as the Scunthorpe General Hospital frailty assessment team (FEAST) model. A proposed frailty model was proposed to the trust management board which would be trialled for a three-month period from May 2018 and evaluated. Following the trial, a business case would be submitted for longer term support based on the findings.

Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to manage demand. The management team worked flexibly to look at new and innovative ways of delivering patient care. We reviewed notes from ED weekly flow meetings where it identified that a medical business plan had been created; this included an additional eight consultants for both hospital sites. The triumvirate completed a business case that was presented to the trust management board in February 2018 regarding increasing the number of medical staff. The paper also discussed further developments to the nursing workforce such as advance care practitioners (ACP) due to the national shortage of junior doctors.

Culture

There had been many changes to the department over the last 12 months such as staffing and records which had provided improvements. Staff felt supported at work generally, however at times there was pressure on the department due to the high volume of patients and demand the morale was lower.

Staff we spoke with wanted to provide effective care and treatment to patients and put patients at the centre of the experience. We observed staff working well together and there were positive working relationships within the multidisciplinary teams.

It was apparent that senior leaders, ward managers and shift leads were proud of their staff and praised them in their work. They felt that staff often went above and beyond to provide care to patients when the hospital was under extreme pressure. The department manager told us they would often put out emergency calls to their staff to come in to provide extra support and they would. During our inspection attendance to the department was one of the highest levels seen and there was an increase in ambulance handovers in a short period of time. The department manager stayed late and three extra staff came in and provided support at very short notice.

The chief executive acknowledged that staff worked well and thanked them for their contribution. Staff had received acknowledgement of their work and how the department had changed from one of the worst performing trusts to 12th in the country.

Staff success was celebrated through trust events where individuals and departments could be nominated. Nominations from both staff and patients allowed patients achievements to be recognised and rewarded. Staff on the department participated in a ‘kind hearts’ initiative. This involved staff nominating individuals within the department to receive a monthly award for their work contribution. We spoke to staff who had won the award who felt honoured and humbled that staff had nominated them. The initiative was completed by one staff member who collated all the staff’s nominations and provided the awards themselves.

Staff would have an informal debrief immediately following specific patient complications or incidents. Afterwards a more detailed debrief would take place which included other agencies such as safeguarding and ambulance staff. Staff told us they were supported if they were required to complete police statements.
Governance

The medicine group had a clear governance structure. Governance structures were in place that provided assurance of oversight and performance against safety measures. We reviewed the quality governance and assurance committee minutes and found discussion around current risks and performance.

A weekly ED flow meeting was in place where performance, ambulance handovers and any other relevant information was discussed.

The shift lead would complete daily checks to provide assurances that the appropriate care was being given to patients. These included reviewing one set of care records in each area to identify if assessments were completed such as care rounds. We observed the checklists to ensure that these had been completed.

An ED dashboard was in place that allowed certain information over a month to be reviewed. This looked mainly at documentation of nursing records and reviewed the patient's observations, assessments and experience. Some of the responses were ambiguous, with figures not tallying and required further analysis to understand the answer. For example, in April 2018 on the dashboard it identified that out of 150 records, five patients presented with safeguarding concerns. The next question asked, 'if yes was a safeguard referral completed?' the responses identified that five records indicated yes and 27 records identified no, with a further 118 records responding with a not applicable response.

The medicine directorate supported medical staff and provided quality and safety meetings which allowed staff to learn from incidents and focus on quality improvement and patient safety.

The department had a quality and safety meeting twice a week and quality audit meetings monthly. We observed one of the meetings and staff discussed patients that attended the department. Staff participated in the learning, asked questions and looked at how they would review patients.

Staff were aware of their role and responsibilities within major incidents. A major incident plan (MAJX) was in place and accessible for staff. Testing days had been held to review the efficacy of the department and how it would participate in a major incident. Staff within the department were involved and participated in the training. Training was completed by the trust in relation to chemical, biological, radiological and nuclear (CBRN) hazards. There was a department lead who managed the CRBRN and MAJX together.

There was a trust-wide paediatric and ED forum which reviewed patient cases, incidents and communication issues. Although in the April 2018 meeting there were no attendees from ED, however the meeting went ahead to review patient cases from ED.

Joint meetings were held between both ED departments at the trust. This enabled discussion about updates, processes to be followed and to ensure consistency across the trust. This included recruitment programmes and clinical governance meetings for both EDs.

Management of risk, issues and performance

There was a departmental risk register, which measured the impact and likelihood of the risk and documented the controls and mitigations in place to manage the risk. The risk register reviewed all the risks for the medicine group and contained risks to the generic group such as ongoing recruitment issues with medical and nurse roles. It identified that there were significant gaps in the medical rota within ED and how to mitigate the risk. The risk was reviewed periodically to identify if there was any changes. It also identified that there was a need to review the skills and experience of the staff working with children in the department and paediatric pathways were created to
support staff. The risk register did not reflect that they were not meeting the RCEM guidelines regarding registered sick children nurses (RSCN) and how they would increase the numbers.

We requested an up to date risk register to identify if any new risks had been added. We found that the risk register did not contained some of the concerns we found at the inspection such as gaps with the GP cover which then impacted on the department. Ongoing issues with escalation between specialities and the lack of services such as FEAST at this site were not on the register as a risk. All these had an impact of increasing the patient’s stay in the department and patient experience.

The department manager was sighted on the issues relating the low numbers of RSCNs and staff had completed further training in paediatrics to mitigate the risk. These included a number of staff completing extended resuscitation training to provide more in-depth knowledge and skills.

The senior management team were aware that further work was needed to embed the 10 steps for improving the emergency care pathway. This was a pathway introduced in 2010 that allowed certain decisions to be made by ED staff to admit and discharge patients into specific areas. For example, issues with admitting patients; the divisional clinical director told us that there had been incidences when it had been escalated to them and they had to become involved for the patient to be accepted by the speciality team. We reviewed weekly ED flow meeting minutes and saw in February 2018 that surgical doctors were refusing to accept patients until there was a vacant bed for them. It identified that a meeting was required between the two directorates to escalate the concerns regarding the issues with patient flow. However, this had not yet taken place.

The senior management team were aware that patients were being referred back from the GPs within the department to ED inappropriately due to their lack of experience or due to no GP on duty. This meant that attendance to the department would increase as the patients were not being seen in the most appropriate place.

A two-hourly department walk round was completed by the shift lead who assessed the department and the capacity, demand and needs of patients. This allowed the shift lead to have an overview of the department and moved staff to specific areas to support with any hot spots of activity or where patients may be waiting. We saw medical staff reviewing patients in the minor injuries department; however, we were told that this did not always happen.

The shift lead attended operational meetings that discussed the overview of each area within the hospital. The shift lead would use the ASH matrix at the meeting and agree a plan as to how they were going to improve patient flow in the department. We attended the operational meeting where the shift lead reviewed the ASH matrix with the director of operations. Patients who had been in the department for a long period of time were discussed including if any further investigations or reviews were required. Ambulance performance was reviewed identifying that they had no delays. Performance standards were also reviewed at the meeting. We observed in the meeting a discussion about which clinical specialities were in-reaching into the department together with requests to attend the department to help with the access and flow. These included speciality doctors reviewing patients; we saw that they attended the department and patients were reviewed.

The department had a contingency plan in place for increasing trolley capacity within the department in times of crisis. Staff told us that they had not needed to activate the increased bed capacity over the winter period as they had managed to ensure patients had been transferred to more appropriate places such as the wards.

Staff were aware of their role and responsibilities in the event of a major incident. Several processes were in place such as business continuity plan, escalation and major incidents. These were accessible to staff who were able to discuss them with us.
Information management

There were several information systems that provided the hospital with up to date information. The ED live dashboard allowed the hospital to see the number of patients that were in the department and any potential breaches of standards regarding how long the patients had been there. The live dashboard could also link across to Scunthorpe General Hospital so that the information could be shared. When the trust’s escalation and surge policy was activated, due to increased demand in the department a text alert would be generated by the system to inform staff in the hospital.

Other electronic systems in the department allowed patient information to be uploaded and shared. There were portable electronic devices in the department that allowed staff to complete clinical information which would show on the system. Receptionists within the department had access to the ambulance staff’s handover system and allowed them to book the patient into ED on arrival. We observed good practice in relation to information security, staff locked their computers and the systems did not show full patient details.

The department collected information to monitor and manage performance in regards to national and local indicators. These were collated into information that was shared with the team and trust board for review and action as required.

Staff told us they had access to information in order for them to undertake their roles effectively. This included access to the trust intranet where policies, procedures and protocols could be accessed and updated. Staff also had access to information about the treatment of injuries and conditions which reflected best practice guidance.

Important information such as safety alerts, incidents and changes to policies and procedures were cascaded to staff by the department manager by email or other methods so that appropriate adjustments could be made.

Engagement

Staff told us they had been involved in developing improvements in the department and what they felt was good right now. This was displayed on a board with key words that they staff had chosen what had changed within the department. These included the introduction of the streaming nurses, extra training and supervision. Some staff had written a summary which was displayed on the board of what they had felt had changed and how they felt part of a supportive team; one member of staff told us that they felt part of a family.

The department manager told us of meetings they were having with specific groups in how they could provide a positive experience for patients that may be reluctant to attend. Also within the meetings they were discussing about how to encourage specific groups to attend where appropriate.

Staff told us that they attended team meetings and felt they participated and were listened to.

The department participated in the friends and family test and CQC Accident and Emergency survey.

The department staff supported each other and engaged with each other through social networking sites. Information was shared through the social networking groups as ward managers had identified that many staff liked this form of communication. Requests for staff to do extra shifts to changes in policies were shared through the private/closed social media groups.

Learning, continuous improvement and innovation

The executive board had invested in the department and provided the opportunity to develop the service. The team had developed new roles such as nurse associates, physician students and two
advance care practitioner (ACP) students that had recently commenced in post. This would support the department as they were unable to recruit into some medical positions. The introduction of Certificate of eligibility for specialist registration (CESR) had commenced to attract and offer a route of progression for medical doctors.

Staff were encouraged to rotate into different areas to improve knowledge, confidence and understanding. We were told of one rotation where a staff member was spending time in the endoscopy department. They felt this would support them in having a wider knowledge base and understanding for when patients attended the department.

The trust was supporting their non-registered staff to apply for nurse associate roles. This included completing further education in core subjects in order to be able to apply for the course.

The operational manager was working closely with the out of hour GP provider to support with the gaps in the GPs rota for primary care streaming.
Medical care (including older people’s care)

Facts and data about this service

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of medical services for patients at all three of the acute hospital sites:

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

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

Admissions for the top three medical specialties were:

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

(Source: Hospital Episode Statistics)

The Trust provides comprehensive acute and non-acute medical services at Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPoW) at Grimsby, on an in-patient and outpatient basis. Outpatient services and sub-acute inpatient beds are provided at Goole District Hospital (GDH). The trust took over the provision of the Neuro Rehab at Goole District Hospital in September 2017.

Acute admissions are generally triaged through the Accident and Emergency / Emergency Department (ED) and the Acute Medical Units (AMU) prior to transfer to the relevant speciality wards. All specialities have access to a full range of diagnostics with patients attending a tertiary centre for more specialised tests or interventions. All services are Consultant led.

There are 419 medical inpatient beds located across all three sites, DPoW provides 195 medical inpatient beds.

A medical service breakdown for DPoW can be found below:

Diana, Princess of Wales Hospital:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amethyst ward</td>
<td>Haematology/Oncology</td>
<td>23</td>
</tr>
<tr>
<td>AMU (Acute Medical Unit)</td>
<td>General Medicine admissions unit including ambulatory care</td>
<td>32 + Ambulatory Care</td>
</tr>
<tr>
<td>C1 Hollies</td>
<td>General Medicine</td>
<td>26</td>
</tr>
<tr>
<td>C1 Kendall</td>
<td>Cardiology</td>
<td>27</td>
</tr>
<tr>
<td>Coronary care unit (CCU)</td>
<td>Cardiology</td>
<td>10</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>General Medicine</td>
<td>25</td>
</tr>
</tbody>
</table>
Is the service safe?

Mandatory training

Medical/ Dental Staff

At this inspection we found that compliance with mandatory training was poor for medical and dental staff. None of the modules at any of the hospitals achieved 85% compliance. Only one out of ten modules (information governance) was close to the 85% target at DPoW the others ranged from 69% for resuscitation training to 33% for fire safety. Junior doctors we spoke with told us they had received an induction and were up to date with their mandatory training.

One locum doctor told us that they were up to date with mandatory training and that this was provided by the agency they were employed by. They told us they had not received a hospital induction or training in the IT systems they needed to use at DPoW.

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for medical/dental in medicine is shown below:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>46</td>
<td>55</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>37</td>
<td>54</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>34</td>
<td>55</td>
<td>62%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>32</td>
<td>55</td>
<td>58%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>28</td>
<td>52</td>
<td>54%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>28</td>
<td>58</td>
<td>48%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>24</td>
<td>55</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>24</td>
<td>55</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>19</td>
<td>55</td>
<td>35%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>18</td>
<td>55</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing Staff

We found that compliance with mandatory training for nursing staff was 82% overall, an improvement on 2016 which was 77% overall. The target of 85% completion was reached in six out of 10 modules across the trust and at DPoW. The lowest completion rate was for fire safety at DPoW which had a completion rate of 74%.
Nursing staff we spoke with told they were up to date with their mandatory training and ward managers and matrons told us that there was sometimes a delay with training completion and the electronic system being updated.

In the Cath Lab mandatory training was reported to be around 96% compliance and staff on C6 told us their area was at 100% Staff on C1 Kendal were up to date or had dates booked in to catch up on training, the ward manager kept a book of which staff were due training each month. Endoscopy staff told us the unit manager had a system in place to remind them if their training was due. Staff on the stroke ward told us it was difficult to keep on top of mandatory training and they tried to get it done on a night shift when it was quieter and there was better access to computers but sometimes they did it at home.

For new starters most, mandatory training was delivered through a two week ‘care camp’. There was an induction booklet for staff to use with agency staff and we saw this was in use.

Therapy staff on the stroke ward told us they had received a trust induction and an induction to their area of work.

A breakdown of compliance for mandatory courses for nursing staff in medicine from February 2017 to January 2018 is shown below:

**Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>193</td>
<td>205</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>190</td>
<td>205</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>179</td>
<td>205</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>175</td>
<td>202</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>176</td>
<td>205</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>171</td>
<td>202</td>
<td>85%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>170</td>
<td>205</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>162</td>
<td>205</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>160</td>
<td>205</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>152</td>
<td>205</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

The Chief Nurse was the executive lead for Safeguarding within the organisation and an operational Head of Safeguarding who was the strategic lead and manager of the Safeguarding team. The trust had three safeguarding forums for Children, Adults and PREVENT which reported into the Quality and Safety committee a subcommittee of the Board. The head of the safeguarding team reported directly to the trust’s chief nurse.

There were five safeguarding referrals from the medical wards at DPoW from February 2017 to January 2018. Although there were no themes from these referrals there were elements of discharge, documentation, communication and medicine issues that were echoed in referrals from medical wards at SGH.

The trust had safeguarding policies available to support staff, these could be accessed on the trust intranet.
Nursing and medical staff we spoke with could describe the processes they would use if they had a safeguarding concern, there were identified safeguarding leads and staff knew where to go to for advice or support. Staff told us that they attended safeguarding training and were up to date with training requirements.

The trust set a target of 85% for completion of safeguarding training. For the trust overall, medical staff compliance was between 72% and 75% for the different modules. Compliance for medical staff at DPoW was between 80% and 84% and 83% to 87% for nursing staff, close to or better than the trust target.

Medical / Dental Staff

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical/dental staff is shown below:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>46</td>
<td>55</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>45</td>
<td>55</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>44</td>
<td>55</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing Staff

A breakdown of compliance for safeguarding courses for nursing staff in medicine over the same period is shown below:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>179</td>
<td>205</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>176</td>
<td>205</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>171</td>
<td>205</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

We found wards and departments to be visibly clean and tidy. In most areas we found equipment was visibly clean and labels were used to identify ‘cleaned and ready for use’, sharps were being disposed of correctly and were signed for. Disposable curtains were in use and had recently been changed.

Patients and relatives told us the ward areas were cleaned regularly. Hand-washing facilities were available on all wards we visited. Personal protective equipment (PPE) including aprons and gloves, and sanitising hand gel were also available.
We observed staff using appropriate personal protective equipment when completing clinical tasks. They complied with hands bare below the elbows national best practice, correct handwashing technique and use of sanitising hand gels was observed. However, we also observed some instances where gel was not used between patients for example on consultant ward rounds.

Side wards were available on all wards. We saw notices displayed on doors where patients with infections were being cared for and doors were mostly closed in line with policy for managing infectious patients. However, we did see an open cubicle door on the stroke unit where a patient was being barrier nursed.

Staff told us that haematology and oncology patients were usually accommodated in separate bays from medical outliers wherever possible, to reduce the risk of infection and that separate side rooms were used for patients who were immunocompromised. Sometimes there was mixing of medical outliers and haematology / oncology patients in same bay. If this happened, it was flagged with the infection, protection and control nurse and logged as an incident.

We saw that some patient information about infection prevention and control was displayed on Amethyst ward e.g. about preventing blood stream infections.

Staff completed infection prevention and control training; compliance for nursing staff across the medical service was 75% and 78% at DPoW, below the 85% target. Medical staff compliance with this training was very poor 32% across the trust and 35% at DPoW. (See mandatory training breakdown above)

We saw there were monthly infection control audits, across the trust medical wards, carried out by ward staff, matrons and infection prevention and control nurses (IPCNs) who looked at ten indicators which included cleanliness of the environment and equipment, hand hygiene facilities, disposal of waste including sharps and clinical practice. From April 2017 to March 2018 overall compliance with the range of indicators ranged between 76% and 97%. Scores given by the IPCNs tended to be lower than those awarded by the ward staff. Compliance was mostly above 95% for hand hygiene facilities and clinical practice over the year and never fell below 85%. Compliance was more variable for cleanliness of general environment, patient equipment, storage areas, waste and linen disposal and sharps safety. The trust did not provide a breakdown by hospital site or ward.

From April 2017 to March 2018 general environment audit compliance, at trust level, was consistently the worst performance of all the infection control indicators and only scored over 90% on two occasions out of twelve, at least one of the auditors scored this indicator below 85% (red rated) every month. The trust did not provide a breakdown of site or ward.

**Environment and equipment**

The trust provided the results of the August 2017 patient led assessment of the care environment (PLACE) assessment. Patients gave this trust an overall score of 98% for cleanliness. This was the same as the national average.

Most wards we visited were clutter free, visibly clean and well maintained. However, there was limited storage space, no sinks in bays and limited toilet facilities in some of the wards

We saw good practice on the endoscopy unit where all stock items were labelled with cost per item to encourage staff to think about what they were using and whether they needed to open new packs etc.
However, we saw that the door to the dirty utility room on the stroke ward and the treatment room and sluice on C5 were not locked giving access to various equipment and solutions including, scalpels, irrigation fluid, actichlor tablets and made up solution. The equipment store on C5 had some items with ‘I am clean’ tape but no date or signature and some items in this room were visibly dusty.

Staff on most wards told us that they had sufficient equipment to support them to safely care for patients. This included pressure-relieving equipment and moving and handling equipment. Staff on Amethyst ward told us they could obtain bariatric equipment the same day for patients who required this.

Medical devices we looked at were labelled to indicate when it was last serviced or checked for electrical safety and to identify next test dates.

Emergency resuscitation equipment on each ward had daily checks completed in line with policy. We checked consumable items, such as gloves, oxygen masks and suction equipment and did not find any items that were out of date on the trolleys. However, we saw that not all daily checks had been completed for all resuscitation equipment on Amethyst ward.

We saw there were dementia friendly(coloured) toilet door frames and toilet seats in the Cardiac Cath Lab and signs with photographs on toilet and bathroom doors on C6.

We saw a large treatment chair had been stored in the fire escape area on Amethyst ward, as it was broken. When raised with ward manager, this was immediately recognised as a hazard and removed. A patient told us that a lock had broken and someone had been stuck in a toilet. This had been reported and was due to be fixed.

**Assessing and responding to patient risk**

The National Early Warning Score (NEWS) is a tool that is used to alert health care practitioners to deteriorating patients and therefore trigger an escalation of care and review of the unwell patient. We saw that staff used NEWS which were recorded in the notes we reviewed, we saw that NEWS scores were calculated and patients were escalated appropriately in most areas. We saw doctors responding quickly to escalated NEWS scores on C6. However, we had some concerns regarding escalation of elevated scores on Amethyst and delayed input of recorded observations. We also found that a patient had not been referred for a mental health assessment despite this being requested on the admission letter from the GP. When we pointed this out to the sister they told us they would make an immediate referral to the MacMillan service for a psychological assessment.

The trust also used a nationally recognised sepsis-screening tool. Where applicable, we saw sepsis-screening tools in the notes we reviewed. The trust had achieved around 80% compliance with screening of appropriate acute adult inpatients for SEPSIS in the three months prior to the inspection.

Recording of physiological observations was audited and reported as part of the nursing audit dashboard. The data for November 2017 showed that medical wards at DPoW were 100% compliant for vital signs recorded with the planned frequency and the appropriate response actioned. Other nursing dashboard audits were; of falls, skin and food and hydration and patient safety indicators. The dashboard for November 2017 showed that more than 95% of risk assessments were carried out within six hours of admission. Areas for improvement were following of the pressure area care pathway which showed 75% compliance.

We saw that patients undergoing procedures in the Cardiac Cath Lab had access to senior medical staff on site if they became unwell during or after a procedure.
We saw that staff on C1 Kendall had triggered the ‘absconded patient policy’ when a patient with multiple physical and mental health problems had left the ward without letting staff know.

We saw staff in ambulatory care using capillary blood glucose monitoring and foot mapping for diabetic patients.

Within the care records we reviewed we saw that staff assessed patients for risk of falls, pressure damage risk, moving and handling, risk of malnutrition, use of bedrails and venous thromboembolism (VTE). We saw individualised risk based plans of care were implemented for patients and where necessary patients had been referred to appropriate specialist teams, for example physiotherapists and dieticians. However, we noted VTE assessments were not always completed within 24 hours in line with the National Institute for Health and Care Excellence (NICE) clinical guideline [CG92]. Staff told us these were usually completed but there could be a delay.

Staff told us that doctors responded quickly when patients were escalated and there was a critical care outreach team out of hours to support the medical on-call team.

We saw staff in the endoscopy unit used a world health organisation (WHO) safer surgery checklist for patients undergoing procedures.

Staff on Amethyst told us they had designed a telephone handover sheet to check and capture key issues for patients coming on to the ward, to ensure appropriate care could be given.

Non-Invasive Ventilation (NIV) was started in the high dependency unit and patients only went to the ward when established on it. An outreach nurse was available for support for 24 hours, seven days a week.

**Nurse staffing**

In 2016, although staffing had improved from 2015, we were still concerned about the impact of staffing levels on patients and staff in medical services. In January 2018 the trust had a qualified nursing staff fill rate of 96.2%, with 12.1 fewer WTE staff in post than the trust planned to provide safe and effective care. All three hospitals reported less staff in place than was planned. For the previous year (January 2017) the trust reported a slightly higher staff fill rate of 97.5%, however the planned whole time equivalent (wte) had risen for DPoW as had the actual number of staff in post from 2017 to 2018.

The trust reported their qualified nursing staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>158.4</td>
<td>154.0</td>
<td>152.9</td>
<td>148.8</td>
</tr>
<tr>
<td>Goole District Hospital</td>
<td>13.1</td>
<td>12.8</td>
<td>13.3</td>
<td>12.4</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>145.5</td>
<td>138.2</td>
<td>133.2</td>
<td>130.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>317.0</strong></td>
<td><strong>304.9</strong></td>
<td><strong>299.3</strong></td>
<td><strong>291.7</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)
Overall staff reported that they felt the nursing staffing situation had improved slightly since the last inspection. Nurses and managers told us there had been some staff retention issues with overseas nurses who had moved on to other trusts or returned home. However, they also told us of some successes where staff had stayed and developed. Some of these staff had been successful in securing promotion to more senior nursing roles.

There were ongoing advertisements and recruitment campaigns for registered nurses and HCAs there had been a recent job fair which had been very successful in terms of recruiting HCAs. Secondments had been given to staff to work on different areas to encourage staff to work in areas that were more difficult to recruit to and posts had been offered to and accepted by two agency staff who regularly worked on the medical wards.

Ward managers told us when staff are moved and this was considered unsafe they would ‘red flag’ this and submit and incident report.

We found that the trust had acted to ensure that acute admission wards such as the Acute Medical Unit (AMU) at DPoW and the Clinical Decisions Unit (CDU) at SGH always had adequate staffing levels. However, this meant that staff from other wards and departments were moved to work in these areas if staffing levels fell below those planned.

Staff on CCU told us that most vacancies were filled but staff were sometimes moved at short-notice to cover other areas. Staff in other areas told us that moving staff at short notice could leave their own ward feeling unsafe at times. They felt the operational matrons were supportive if this was raised as an issue but site managers were not, and had been quite ‘harsh’ with junior staff leaving them very upset. Staff felt unable to refuse to move a member of staff or accept a patient when they felt unsafe. They said they were speaking out about this but nothing was changing.

CCU staff told us that sometimes up to four additional beds were opened on the coronary care unit due to winter pressures, however staffing was difficult as no additional nurses were allocated, meaning 2 registered nurses were caring for up to eight patients at night.

Staff also reported that when they were re-deployed to A&E they did not always feel competent to do so and staff in that area were sometimes derogatory if they could not undertake a certain task such as cannulation.

Staff told us that when additional beds were opened on C8, due to winter pressures, that staff were available to look after these areas.

During our inspection we saw that a member of staff was moved from C6 the gastro-enterology ward to cover another area. This meant the planned staffing of four RNs and three HCAs was short of one RN. Mitigations put in place were the shift leader taking a cohort of patients to look after. We saw that there was an additional HCA on duty for the day and night shifts however this had been arranged in advance as there were a number of patients on this ward who needed close supervision because of confusion and high falls risk, as well as a patient with a DoLS in place.

We saw from the storyboard on C6 that the ward had filled eight out of ten RN vacancies but not all had stayed. There were four vacancies on the ward at the time of inspection. Specialist nurses told us that they were sometimes redeployed to work clinically on wards when they were short staffed.

The planned staffing level for RNs on the stroke ward was not met for the day shift (there was 1 RN down), the shift leader told us the agency nurse had not arrived. There were no issues with RNs for the night shift and HCA staffing met the planned level for morning and night with one gap in the afternoon/evening. Staff told us staffing levels were not good and staff were often moved to other areas, staff had been moved to C2 when winter pressure beds were opened and that the last
few months had been very tough. They told us staff were leaving and it doesn’t feel like they are being replaced. Staff reported agency staff were generally good and the team was supportive.

We observed two patients calling for a nurse and one elderly patient getting up and looking for a toilet in a bay on C5. There was no staff in the area at the time as the HCAs had been called away to see to a patient who was at risk of falling in another bay, when the registered nurse was involved with the ward round. The HCAs appeared stretched but were polite and professional. Call bells on this ward took between three and nine minutes to be answered.

Staff on B4 which should have been a surgical ward but was full of medical patients told us they were expected to support some surgical outpatient clinics which was very difficult due to the acuity of the patients on the ward.

Staffing on C1 Holles was at the planned level for both day and night shifts on the day of our inspection. However, staff reported that they were frequently moved off this area to cover other wards, especially A&E and AMU.

AMU staffing met that planned during the inspection except for one RN short for the afternoon. A student nurse told us that staffing levels felt adequate and they were never asked to do anything beyond their level of competence. There were 5 wte RN vacancies across AMU and ambulatory care and a 0.4 wte HCA vacancy.

We reviewed staffing on Amethyst ward on the day of inspection (23 patients) and we saw it did not meet the planned levels for the afternoon shift. Planned staffing for the morning and afternoon shifts was 4 registered nurses (RNs) (1 co-ordinator and 3 on the ward) and 3 HCAs. Actual staffing for the morning shift matched this, although the afternoon shift only had 3 RNs. Planned staffing for the night shift was 2 RNs and 2 HCAs and this was covered. Staff told us they felt staffing numbers at night could be improved. Staff told us it was not always possible to get additional staff to provide 1-1 supervision for falls risk or confused patients and that the shift co-ordinator often had to take patients to fill the gaps.

The trust held operational management meetings four times each day to establish patient flow issues, staffing issues and the capacity and demand on each hospital site. The meetings were attended by staff from a number of disciplines from within the hospitals and included, social workers, pharmacy and transport. Appropriate staff from wards attended to report discharges for the day and escalate staffing or patient flow issues such as delayed discharges. Staffing plans were made for the next shift at these meetings although they were subject to change if additional staff called in or if bank or agency staff did not arrive as expected.

In addition, a daily staffing meeting took place to ensure staffing levels were reviewed across the Trust and short-term plans were put in place. This ensured appropriate escalation and timely requests for additional duties or temporary staffing to respond to patient needs. Managers told us this was a daily challenge and they used a Red, Amber, Green system to prioritise the redeployment of staff.

On the day of our visit C1 Kendal had the planned number of RNs and HCAs on all shifts.

We saw that AMU had a care navigator / flow coordinator as part of their team, staff valued this role and said it took a lot of pressure off RNs regarding liaison with nursing homes, community care agencies and arranging transport, equipment and care packages for discharge. The feedback was that discharges were much smoother and better organised when this role was available. (can get home Oxygen in 4 hours when patients ready for discharge).

We saw that the medical wards supported student nurse placements.
Average fill rates for the medical wards at DPoW from February 2018 to April 2018 are given in the table below, however, there are some gaps in data availability. From the data available there was only C1 Hollies and C5 Respiratory with fill rates of less than 80% for one of the three months reported. Overfill with care staff was explained by managers as being one of the ways they tried to mitigate for a shortfall of RNs.

<table>
<thead>
<tr>
<th>Ward / unit</th>
<th>Inpatient beds</th>
<th>Date</th>
<th>Registered midwives/ nurses</th>
<th>Care staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Day</td>
<td>Night</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Day</td>
<td>Night</td>
</tr>
<tr>
<td>Amethyst ward</td>
<td>23</td>
<td>01 Feb 2018</td>
<td>98.00%</td>
<td>95.80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Mar 2018</td>
<td>92.50%</td>
<td>104.20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 April 2018</td>
<td>92.90%</td>
<td>101.70%</td>
</tr>
<tr>
<td>AMU (Acute Medical Unit)</td>
<td>32 + Ambulatory Care</td>
<td>01 Feb 2018</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Mar 2018</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 April 2018</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>C1 Hollies</td>
<td>26</td>
<td>01 Feb 2018</td>
<td>80.40%</td>
<td>97.70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Mar 2018</td>
<td>76.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 April 2018</td>
<td>81.40%</td>
<td>96.70%</td>
</tr>
<tr>
<td>C1 Kendall</td>
<td>27</td>
<td>01 Feb 2018</td>
<td>81.70%</td>
<td>99.30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Mar 2018</td>
<td>81.80%</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 April 2018</td>
<td>100.00%</td>
<td>0%</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>25</td>
<td>01 Feb 2018</td>
<td>77.90%</td>
<td>96.60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Mar 2018</td>
<td>83.10%</td>
<td>96.90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 April 2018</td>
<td>86.80%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Ward C5</td>
<td>26</td>
<td>01 Feb 2018</td>
<td>81.70%</td>
<td>99.30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Mar 2018</td>
<td>74.30%</td>
<td>97.40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 April 2018</td>
<td>102.80%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Ward C6</td>
<td>26</td>
<td>01 Feb 2018</td>
<td>80.10%</td>
<td>89.40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Mar 2018</td>
<td>82.60%</td>
<td>99.80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 April 2018</td>
<td>85.30%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Vacancy, Turnover and Sickness Rates

We found that DPoW continues to have qualified nurse vacancies slightly above the trust target. The turnover rate was also slightly above the trust target while the sickness rate was at trust target level.

From February 2017 to January 2018, the trust reported an annual vacancy rate of 14% for qualified nursing staff in medicine which was higher than the trust target of 6.3%. The vacancy rate for DPoW was 7%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
From February 2017 to January 2018, the trust reported an annual turnover rate of 14% for qualified nursing staff in medicine which was higher than the trust target of 9.4%. The turnover rate for each of the hospitals are:

- Diana, Princess of Wales Hospital: 10%
- Scunthorpe General Hospital: 19%
- Goole District Hospital: 15%

None of the hospitals met the trust’s target for turnover rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From January 2017 to December 2017, the trust reported an annual sickness rate of 5% for qualified nursing staff in medicine which was higher than the trust’s target of 4.1%. Sickness rates for the three sites are shown below.

- Diana, Princess of Wales Hospital: 4%
- Scunthorpe General Hospital: 5%
- Goole District Hospital: 1%

Scunthorpe General Hospital was the only site that did not meet the trust’s target for sickness rates. (Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

From February 2017 to January 2018, the trust reported the following nursing bank and agency staff usage by site:

**Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Assistants</td>
<td>-</td>
<td>2,679 (48.9%)</td>
<td>1,019 (18.6%)</td>
<td>5,480</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>1,555 (24.7%)</td>
<td>2,042 (32.5%)</td>
<td>1,024 (16.3%)</td>
<td>6,289</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018 there was a total of 19,737 ‘available shifts’ (i.e. unfilled by substantive staff) for qualified nurses 40.1% were filled by agency nurses and 25.1% by hospital bank nurses. This means that 14.2% (2,796) of available qualified nursing shifts remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Pharmacy staffing**

Ward and pharmacy staff raised concerns regarding vacancies in the pharmacy team and apparent problems with retention of staff. The impact of the vacancies was felt to be insufficient cover for some ward areas, for example the CDU pharmacist was often asked to cover the emergency department because of vacancies. Pharmacists also felt there was a risk in the lack of capacity to oversee and screen / audit adequate numbers of over labelled packs and discharge prescriptions. Pharmacists told us there was difficulty attracting and retaining staff. They felt that helping with suitable accommodation, other help for staff and recognition was needed.
Medical staffing

The trust has reported their medical staffing numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>55.1</td>
<td>54.8</td>
<td>55.1</td>
<td>55.8</td>
</tr>
<tr>
<td>Goole District Hospital</td>
<td>4.6</td>
<td>5.5</td>
<td>4.4</td>
<td>5.2</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>51.3</td>
<td>52.4</td>
<td>51.1</td>
<td>53.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111.0</strong></td>
<td><strong>112.7</strong></td>
<td><strong>110.6</strong></td>
<td><strong>114.2</strong></td>
</tr>
</tbody>
</table>

In January 2018 the trust had a medical staff fill rate of 101.5%, with an over-establishment of 1.7 more WTE staff in post than the trust planned to provide safe and effective care. Goole District Hospital and Scunthorpe General Hospital both had an over-establishment of medical staff, whilst Diana, Princess of Wales Hospital had a fill rate of 99.6%, with slightly less WTE staff in post than planned.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy, Turnover and Sickness Rates

From February 2017 to January 2018, the trust reported a vacancy rate of 28% in medicine, the vacancy rate for each of the hospitals is given below;

- Diana, Princess of Wales Hospital: 24%
- Scunthorpe General Hospital: 30%
- Goole District Hospital: 58%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From February 2017 to January 2018, the trust reported a turnover rate of 8% in medicine;

- Diana, Princess of Wales Hospital: 9%
- Scunthorpe General Hospital: 7%
- Goole District Hospital: 0%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From January 2017 to December 2017, the trust reported a sickness rate of 3% in medicine;

- Diana, Princess of Wales Hospital: 2%
- Scunthorpe General Hospital: 3%
- Goole District Hospital: 0%
Bank and locum staff usage

From February 2017 to January 2018, the trust reported the following shifts for bank and locum staff:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>99</td>
<td>2252</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>99</td>
<td>2,252</td>
<td>15</td>
</tr>
<tr>
<td>Doctor in training</td>
<td>657</td>
<td>3,297</td>
<td>123</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>626</td>
<td>513</td>
<td>5</td>
</tr>
</tbody>
</table>

The trust did not provide the total medical and dental shifts available; including substantive staff therefore, bank and locum usage cannot be calculated.

Staffing skill mix

In October 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 107-whole time equivalent staff working in medicine at Northern Lincolnshire and Goole NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (SpR) 1-6
* Junior = Foundation Year 1-2

*Source: NHS Digital - Workforce statistics (01/10/2017 - 31/10/2017)*

Medical staff told us that staffing at night and at weekends for the medical service was one Specialist Registrar (SpR), one Senior House Officer (SHO) / middle grade doctor and one
Foundation Year One or Two doctor (FY1/2). There was a consultant available on-call and a critical care outreach team available at night. We were aware that the local deanery was not placing Cardiology FY1 and FY2 doctors at the trust as there had been a lack of support and teaching available due to consultant pressures. The trust had recently appointed a new clinical tutor who would look at this as part of their role. Doctors told us that consultant vacancies and reduced medical cover caused delays in patients being able to have procedures, delayed decision making and delayed discharges.

Doctors felt that discharge planning could be improved by better forward planning and perhaps criteria or nurse-led discharge.

There was teaching for junior doctors on the medical grand round weekly, and twice weekly lunchtime sessions for junior doctors. Juniors felt the quality of the teaching was very good. One junior doctor told us they had been in post one month and their clinical supervisor had not been assigned yet. However, junior doctors told us that senior support was easily accessible.

Nurses on C6 told us medical cover on the ward was not good and they spent a lot of time chasing up doctors to carry out tasks on the ward. Staff on B4 told us that the ward was full of medical outliers and although they had a buddy system, they really needed a medical doctor based on the ward. However, they told us the patients were reviewed daily during the week and that a clear plan of care was left for the weekend, which would include if patients needed reviewing by the on-call consultant.

We spoke with a patient on AMU who told us they had been waiting two days for a cardiology review. There was a dedicated medical registrar on duty for the ambulatory care unit 9am to 5pm every day, the weekdays until 5pm to 7pm was covered by the on-call registrar. Doctors told us there were shortages mainly at registrar level and of senior cardiologists.

Staff told us that an Acute Physician reviewed all patients on AMU every morning and the on-call consultant sees any new patients in the evening. There had been a recent speciality in-reach pilot project involving speciality consultants reviewing patients in AMU to facilitate discharge, however, staff had not heard the findings of this yet.

Amethyst ward had two doctors – one oncology and one haematology, who were buddied with two endocrinology doctors who oversaw any patients who were outliers on the ward. Staff told us access to doctors was not as easy for patients who were outliers. Staff told us that out of hours they sometimes found it difficult to get medical staff to the ward in a timely way, they could be waiting three to four hours to get a doctor to rewrite prescription sheets. Staff would escalate to a registrar or consultant if urgent and report long delays as incidents. Staff told us a registrar had recently been appointed which had helped with consistency and support for junior doctors.

**Records**

The Trust is going through a transition from paper records to the Acute Electronic Patient Record in WebV which meant that both were required to be used.

Data provided by the trust, showed that 84% of medical staff and 86% of nursing staff at DPoW had completed information governance training, around the trust target of 85%.

We did not have any concerns about the security of records on most wards we visited. However, we saw that the notes trolley on C6 was unlocked and the confidential waste bag on the stroke unit was open allowing documents to be read.

We looked at 36 sets of medical records belonging to medical patients at DPoW and found that 34 had a clearly documented history and plan of care. However, there were 24 patients where it was not clearly documented whether they had been reviewed within 14 hours, of admission, by a
consultant or whether they had regular consultant reviews. This was because the designation of the reviewer was not always documented. There was clear evidence of input from professionals from multidiscipline in all but one record. There was a clear three-day gap for one patient being reviewed. Thirty of 36 records had gaps in dates and signature and 24 of 36 records were extremely difficult to read. Nine of thirteen records did not have DNACPR status recorded. Nursing records were of a good standard with all risk assessments recorded.

A trust-wide audit of adult nursing documentation across all three hospitals in April 2018 had given the trust moderate assurance. This was an improvement on the previous audit which only gave limited assurance. Some of the areas that needed further improvement were identifiers on every page such as patient name, date of birth, NHS number and consultant. Discharge plans and checklists were also an area for improvement, as was the use of a pain chart and the documentation of evaluation of analgesia effectiveness. As this report was in draft stage there was no action plan developed as yet.

A trust-wide documentation audit of medical records in May 2018 gave limited assurance similar to previous years. Like the nursing audit it showed that recording of demographic / patient identifiers needed to be improved. Documentation of initial assessment using the CDU/AMU clerking document was generally good, however it was also evident that documentation of discussions with patients and or carers about their care needed to be improved and gaps in care were also highlighted by the audit. The trust had developed an action plan to improve practice.

**Medicines**

Inpatients on Medicine, Surgery and paediatric wards received a Medicines Reconciliation Service within 24 hours of admission and a clinical review by a pharmacist (with a prescribing qualification when available). All new medicines were reviewed by a pharmacist but pharmacy did not support discharge. There were two medicines management nurses to support the safe use of medicines trust wide. Staff told us that the wards received a daily visit from a member of the pharmacy team, Monday to Friday.

Nursing staff on some wards dealt with pharmaceutical stores as they did not have the same pharmacist each day.

We checked that medicines, including controlled drugs were stored safely and securely on most wards. However, we found some issues with staff not always signing for receipt of CD stock on C5.

The AMU had pharmacy staff on the ward all day to perform medicines reconciliation, to manage stocks and discharge medicines. Staff on the stroke ward used two nurses to check over labelled packs for discharge medicines to ensure there were no transcribing or labelling issues. Staff on B6 where there were a large number of medical outlier patients worried that labelling transcription errors on discharge medicines may not always be picked up and reported as staff may be unfamiliar with the medicines they were dispensing. Pharmacists felt that there was a risk that this type of incident was under-reported.

We saw evidence on all the wards we visited that nurses checked controlled drugs (CDs) weekly in line with policy and pharmacy staff carried out a 3-monthly check. There were separate CD registers for patients own medicines. However, CD stock on Amethyst needed to be rationalised as there was a very wide range of stock that was unlikely to be used regularly. We found seven lots of patients own drugs that had been left on the ward and not been returned to pharmacy following the patients’ discharge.

We found on C2 (the escalation area) that the system for ordering and storing medicines had changed and medicines were now ordered by and held on AMU in their stock cupboard. However, we found that the disused medicines cupboard on C2 was still full of medicines, some out of date
and some patients own medicines which had not been taken home. It appeared that as this area was staffed by RNs and agency staff that no one had ownership for the area or realised that these medicines needed to be removed / destroyed and pharmacy were no longer checking the cupboard as they believed all stock had moved to AMU.

We also checked the medicines fridges and saw daily minimum and maximum temperature checks were mostly completed on all wards and action taken when readings were outside of the 2-8°C range. However, we saw several omissions in daily recordings in January, February, and March 2018 and two recordings outside the recommended range on Amethyst but there were no notes of actions taken. We saw on AMU that the paper work for expiry and cleaning checks had not been completed for the fridge for three months, there were more than 10 expired or unissued discharge prescriptions left in the fridge.

We found a patient on the stroke ward had six omitted doses of an antifungal mouthwash without a reason being recorded. We also found an incidence of a missed anticoagulant without a recorded reason on B6 which we asked the nurse in charge to investigate and report as an incident if necessary.

We found intravenous fluids were stored safely and potassium solutions were kept separately.

Patients wanting to self-administer medicines had a risk assessment performed and recorded in the patient’s notes before this was initiated, we saw one patient on Amethyst self-administering.

We found liquid medicines did not always a of date of opening recorded, on AMU, stroke unit, and Amethyst. There were a number of loose foils of oral medicines and several open packs of stock medicines on Amethyst.

We found, on Amethyst, that medicine charts were generally completed well with; VTE assessments, allergy status and whether medicines reconciliation had been completed. However, one out of four charts on Amethyst did not have a VTE assessment recorded. On AMU one of three did not have allergy status documented and two of six did not have a VTE assessment completed.

There were a small number of issues with medicine cards; one of three patients where relevant did not have oxygen prescribed or target oxygen saturation recorded, three of eight cards did not have a record of patients’ weights and there was one patient whose medication had been omitted and it was not clear from the chart why this was the case. This had been omitted in response to blood results but this was not clearly documented on the chart.

Part of the adult nursing audit dashboard asked whether there was; more than two omitted doses of one or more medicines, was the reason for omission documented and was appropriate action taken regarding the omitted dose. Cumulative results for the period from January 2017 to November 2017 showed that where omissions were noted the reasons for this were documented and appropriate action was taken in 99.4% of cases.

Incidents

Never Events

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.
From February 2017 to January 2018, the trust reported no incidents classified as never events for medicine.

*Source: NHS Improvement - STEIS (01/02/2017 - 31/01/2018)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from March 2017 to February 2018. This is almost double the amount covered by the period reported at the last inspection from August 2015 to August 2016 (11).

A breakdown of the incident types is shown below:

- Six medication incidents meeting SI criteria (30% of total serious incidents).
- Four treatment delays meeting SI criteria (20% of total serious incidents)
- Four pressure ulcers meeting SI criteria (20% of total serious incidents)
- Two surgical/invasive procedure incidents meeting SI criteria (10% of total serious incidents)
- Two slips/trips/falls meeting SI criteria (10% of total serious incidents)
- One pending review (5% of total serious incidents)
- One commissioning incident meeting SI criteria (5% of total serious incidents)

12 of the 20 incidents occurred at Scunthorpe General Hospital and eight at Diana, Princess of Wales Hospital. No serious incidents were reported at Goole District Hospital during the period.

A breakdown of the eight incidents occurring at Diana, Princess of Wales Hospital below:

- Three medication incidents meeting SI criteria
- One pressure ulcers meeting SI criteria
- One treatment delays meeting SI criteria
- One slips/trips/falls meeting SI criteria
- One commissioning incident meeting SI criteria
- One incident pending review and no category has been allocated by the trust.

(Source: Strategic Executive Information System (STEIS))

Data provided by the trust showed 2945 incidents were reported by staff on the medical wards at DPoW from January 2017 to April 2018. However, there was no breakdown relating to the degree of harm.

Staff we spoke with were aware of the reporting system and could tell us when they would report an incident. Staff told us a ‘lessons learned’ folders were available on the wards and departments.

One member of staff told us they had not received any feedback from transport incidents they had reported even though they had left their personal details on the system.

Staff were able to give examples of learning from incidents shared at team meetings e.g. incident where patient had not been weighed and had resulted in incorrect dose of medication and an incorrect does of insulin.

Staff on the stroke ward told us they had received some recent training, bought some new pressure relieving devices and a new pathway had been introduced following a rise in the number of pressure ulcers on the ward and across the trust.
Staff told us they received information about received safety alerts. We saw a poster with information about a safety alert displayed on one ward.

One of the quality matrons had a lead role regarding slips, trips and falls and provided training and support regarding falls prevention. The trust had introduced a new ‘Skin bundle’ to help reduce the number of avoidable pressure ulcers.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Most staff could describe the process they used in relation to the duty of candour, and gave examples such as after a fall with harm or when a patient developed avoidable pressure damage.

Managers told us there was work ongoing to improve the mortality review process and more closely align this with the trust’s SI process. As part of the mortality review programme, where a reviewer felt care had been poor or concerning, they would refer for a second review.

We reviewed minutes from the respiratory and gastroenterology department’s mortality and morbidity meetings, which showed discussion and learning points from the review of mortality cases and pathway audit. There was evidence of action to improve the services and identification of factors which may affect mortality outcomes such as: for gastroenterology; length of stay in the emergency department, getting the patients into the right bed and lack of alcohol liaison services. There was also the recognition of things that had made a difference in other services such as having a specialist, respiratory in reach nurse to ensure patients were on the correct pathways and had appropriate care plans. The respiratory minutes highlighted similar issues such as length of stay in ED and the number of deaths outside of the respiratory ward.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 124 new pressure ulcers, 26 falls with harm and 15 new catheter urinary tract infections from December 2016 to December 2017 for medical services.

From June 2017 to May 2018 we saw that the percentage harm free care for DPoW ranged between 83% and 92%. There were five dips in performance over the year of below 70%, four of these were in the stroke unit (June, September, October and November 2017), and one was in C1 Holles April 2018.

We saw data such as the number of pressure ulcers, catheter associated urinary infections and falls displayed on medicine wards, for January to March 2018.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Northern Lincolnshire and Goole NHS Foundation Trust**
Is the service effective?

Evidence-based care and treatment

Staff had access to trust policies via the trust intranet hub. Patient records from both wards showed staff used a number of standardised care pathways to plan care for patients. We looked at some of the trust’s clinical protocols and patient pathways used for patients on medical wards; this included the trust’s stroke, non-invasive ventilation and skin integrity pathways. We found that these followed nationally recognised best practice and current evidence base. The pathways were clear and easy to follow.

The trust took part in several National and Local Audits. There was a monthly programme of nursing indicators for adult inpatient wards which included physiological observations, completion of risk assessments and other patient safety indicators. Results were reported as part of the nursing audit dashboard and identified areas for improvement or where support was needed. One of the quality matrons told us it was hoped to develop further audits for non-clinical transfers and delayed discharges, within the next six to 12 months.

Nutrition and hydration

The August 2017 PLACE audit gave food a score of 77%, which was worse than the national average of 90%.

We saw that food and drinks were left within reach of patients and patients reported that the food offered was hot and presented well. Patients told us that water jugs were changed routinely twice a day and nurse would change them or re-fill them if asked. Hot drinks were offered with meals, mid-morning, mid-afternoon and on an evening. However, on Amethyst ward, we saw one patient

Source: Safety thermometer - Safety Thermometer
meal was delivered and left out of reach while they were asleep. Staff rectified this immediately, when this was raised.

On the stroke ward we saw clear instructions for patients on textured diets or thickened fluids, we observed staff feeding patients and assisting with drinks. Food was available to meet cultural needs and allergies were highlighted on menu cards and catered for. We saw that food and fluid charts were completed well on this ward. There was a variety of drinking vessels available to suit different patients’ needs.

Protected mealtimes were promoted on most of the wards we visited, including AMU. We saw information about this displayed on some of the wards.

Part of the adult nursing audit dashboard covered a number of food and hydration indicators from risk assessments to completion of food and fluid records. Cumulative results for the period from January 2017 to November 2017 showed that completion of risk assessments was 99% for nutrition and 96% for fluid. Completion of fluid charts was 86% and food charts was 92%. Where necessary we saw that patients, who were at risk of malnutrition were referred for specialist advice from dieticians.

Patients in the Cardiac Cath Lab were able to have breakfast pre-procedure and or a snack post-procedure, if wanted. Patients on the endoscopy unit could have a snack and drink procedure if they wanted.

**Pain relief**

We saw that staff checked on the patient’s level of pain routinely as part of comfort rounds and that evaluation of pain was documented in patients’ nursing records.

Trust staff used the Abbey pain scale for patients with dementia and could access specialist nurses for support if needed to help assess pain for patients with learning disability or dementia. Staff told us there was a newly appointed pain specialist nurse and they could also ask the MacMillan nurses for advice if they needed to and a patient’s pain was difficult to control.

One patient on C5 told the consultant on the ward round that they had to wait a long time for their analgesia during the night (one hour) and did not receive their sleeping medicine. The consultant went to speak to the ward manager about the incident to try to ensure this didn’t happen again.

**Patient outcomes**

Occupational Therapy staff on Amethyst told us they used an elderly mobility score (EMS) on admission and discharge and generic patient outcomes measures to evaluate therapy success.

Inflammatory Bowel Disease (IBD) nurses collected information for the national IBD registry.

**Relative risk of readmission**

**Diana, Princess of Wales Hospital**

From November 2016 to October 2017, patients at Diana, Princess of Wales Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in medical oncology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
admissions
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a lower than expected risk of readmission for non-elective admissions

**Elective Admissions - Diana, Princess of Wales Hospital**

![Graph](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*

**Non-Elective Admissions - Diana, Princess of Wales Hospital**

![Graph](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*

**Sentinel Stroke National Audit Programme (SSNAP)**

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest the audit, April to June 2017.

**Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Team-centred KI levels</th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scanning</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2) Stroke unit¹</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>3) Thrombolysis</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4) Specialist Assessments</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
5) Occupational therapy

6) Physiotherapy

7) Speech and Language therapy

8) MDT working

9) Standards by discharge

10) Discharge processes

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 17</th>
<th>Apr-Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>

1 Included in IM reporting, indicator SSNAPD02

**Overall scores**

**Heart Failure Audit**

**In-hospital Care Scores**

Results for Diana, Princess of Wales results were better for two of the four standards and worse for the other two
Discharge Scores

Results for Diana, Princess of Wales, results were better than the England and Wales average for five of the nine standards relating to discharge and worse for four.

SOURCE: NICOR - Heart Failure Audit (01/04/2015 - 31/03/2016)

National Diabetes Inpatient Audit 2017

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to
people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 60 inpatients with diabetes at Diana, Princess of Wales Hospital, 88.4% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile three.

(Source: NHS Digital)

**Myocardial Ischaemia National Audit Project (MINAP)**

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 22.3% of nSTEMI patients were admitted to a cardiac unit or ward at Diana, Princess of Wales Hospital and 92.9% were seen by a cardiologist or member of the team compared to an England average of 55.8% and 96.2%, respectively.

The proportion of nSTEMI patients who were referred for or had angiography at Diana, Princess of Wales Hospital was 75.9% compared to an England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

**Lung Cancer Audit 2017**

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 84.7%, which did not meet the audit minimum standard of 90%. The 2016 figure was 67.4%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 13.7%, this was within the expected range when compared to the national average of 17.5%. The 2016 figure was not significantly different from the national level.

The proportion of fit patients with advanced NSCLC receiving Systemic Anti-Cancer Treatment was 51.4%; this was within the expected range when compared to the national average of 62.0%. The national aspirational standard was 60%. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 67.2%; this was within the expected range when compared to the national average of 68.0%. The national aspirational standard was 70%. The 2016 figure was not significantly different from the national level.

The one-year relative survival rate for the trust was 32.6% which was within the expected range when compared to the national rate of 37.0%. The 2016 figure was not significantly different from the national level.

(Source: National Lung Cancer Audit)
National Audit of Inpatient Falls 2017

Diana, Princess of Wales Hospital:

The trust has a multi-disciplinary working group for falls prevention where data on falls is discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 20%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 3.8%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 25%. This did not meet the national aspirational standard of 100%. The crude proportion of patients with an appropriate mobility aid in reach (if applicable) was 50%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Mortality Outliers

The trust currently has two active mortality outliers. One is under consideration by the outliers’ panel (heart valve disorders from September 2017) and one case where action plans are being followed up by local inspection team (septicaemia (except in labour) from September 2016).

(Source: CQC Outliers Programme)

Competent staff

Appraisal rates

From April 2017 to January 2018; 63.4% of staff within medicine at the trust had received an appraisal compared to a trust target of 95%. Compliance at DPoW was around 65% which was also similar to the previous year’s achievement.

A split by site and staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>99</td>
<td>131</td>
<td>75.6%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>23</td>
<td>31</td>
<td>74.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>131</td>
<td>190</td>
<td>68.9%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>25</td>
<td>73</td>
<td>34.2%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>1</td>
<td>5</td>
<td>20.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
Due to delays in IT systems, ward managers felt that appraisal rates were higher than the downloaded report. Most staff we spoke with told us they had an up to date appraisal.

Wards that were particularly poor for appraisals, at April 2018, were C5 - 0%, CCU - 7%, C6 - 27%, Stroke unit - 31% and Amethyst - 38%.

Staff on C1 Kendal told us they had a nominated appraiser and they received appraisals every year. Endoscopy staff also told us they received appraisals. Cath Lab staff were at 100% for appraisals and 100% supervision. Health care assistants in this department told us they had completed competencies in venepuncture, pre-assessments and admission of patients.

Staff on C1 Holles told us they were well supported with education and training. We saw that Amethyst staffing was planned to ensure there was always one chemotherapy-trained nurse available. Two nurses were in the process of completing this training at the time of inspection, in anticipation of two staff leavers. The ward manager told us staff on Amethyst ward had received some training in patient pressure areas and had not had any pressure ulcers develop since.

Staff told us they were supported with personal/professional development and training to fulfil their role, staff in cardiology told us they had received training regarding catheters and PICC (peripherally inserted central catheter) lines. Most of the RNs on C6 had undergone training regarding insertion of naso-gastric tubes and the intention was that all RNs would completed this training.

A HCA on the endoscopy unit told us they felt empowered to fulfil their role, and were competent and able to work across site.

Specialist nurses such as; respiratory, sepsis, cardiac rehab, tissue viability and diabetic nurses were available to support ward staff with care of complex patients and to provide specialist support and clinical skills training. The diabetic specialist nurses were hoping to increase the amount of training they provided with particular regard to insulin safety.

Staff on C5 were all trained in caring for patients with Non-invasive ventilation (NIV) and a physiotherapist was receiving some training in interpreting chest x-rays.

Staff on B4 felt that they did not always feel confident that they had enough knowledge about medical treatments and medicines to properly care for the medical patients on this ward. Although this was supposed to be a surgical ward, every patient was a medical patient on the day of our inspection. They did say however, that if they needed help or advice they would ring a medical ward for help.

Two staff members on Amethyst were completing palliative care training, as some patients chose to remain on the ward at the end of their life.

Doctors and nurses on the AMU told us there were dedicated training sessions and professional development and quality improvement was encouraged. Medical staff told us there was additional training for delivering bad news and reflection was encouraged as part of appraisal.

There were clinical skills educators employed by the trust to provide education and training to staff in the clinical/ward areas.

Newly recruited staff and student nurses told us they were supported by mentors. Newly qualified nurses said they had a preceptorship period and a supernumerary period when they first joined the trust. Staff told us they were competency assessed during their preceptorship period.
Staff told us the trust provided information and support for NMC revalidation.

**Multidisciplinary working**

Staff we spoke with told us that they had positive and supportive relationships with the multidisciplinary team (MDT) for example, medical staff, specialist nurses, therapists, dieticians, social care workers, mental health liaison and community teams.

Staff on Amethyst ward reported that MDT working was good, medical staff were approachable and available, although getting out of hours medical cover could be a challenge. AHPs reported a good relationship with nursing staff. Doctors reported good communication with nursing team, who were able to identify problems early.

We saw that specialist nurses such as diabetes and respiratory nurses visited patients on the ward and we saw evidence multi-disciplinary input to plans of care and treatment documented in patient records. There were two specialist nurses on ward C6 to support patients with Irritable Bowel Disease (IBD). These nurses provided education and support to patients and had a helpline for patients to contact them. The nurses told us most calls were resolved the same day or the next. The nurses carried out patient reviews on the wards and held their own clinics, they told us they could escalate patients to the associate specialists or the consultants who were supportive.

There was a weekly MDT meeting on the stroke ward to discuss patients’ progress and plans for treatment and discharge. There was a MDT huddle on the stroke ward every morning to plan care, therapy and highlight patients for discharge, for that day. There was good evidence of multi-disciplinary input across specialities and into the community in the records we looked at.

We saw there was good multidisciplinary working on the AMU and patients had access to and support from a well-established multidisciplinary team including nurses, doctors, therapists and social work staff.

We saw that ward and board rounds were held on the wards to discuss patients’ needs and to plan for discharge. However, on C6 we were told that medical staff were not always available to have a multi-disciplinary board round / handover.

B4 had daily multi-disciplinary board rounds which included therapist and members of the social work team.

We found that a patient on C5 had NIV in place but we were unable to find documented instructions regarding this. The RN told us verbal instructions had been given at handover and the patient had been admitted overnight and needed to be reviewed. The respiratory nurse reviewed the patient but left the ward without communicating with the RN. The nursing documentation said to alternate between ‘high flow oxygen and NIV’ but there was no recording of settings, target saturations or criteria for re-starting NIV. We checked on this patient at 10.20, 11.20 and 13.30 and there was still no documentation, the physiotherapist, respiratory nurse and matron were unable to find the relevant written instructions. The matron immediately took action to rectify the situation. NIV is usually started in the high dependency unit and patients only come to the ward when established on it. An outreach nurse was available for support for 24 hours, seven days a week.

We observed a medical handover at morning shift change, this was clear and well-structured with good consultant involvement, patients who had failed discharges or readmissions as well as those who needed escalation for senior review were highlighted. Patients NEWS and sepsis risks were also discussed and the consultant was informed of a patient who was very distressed and wished
to make a complaint. There was good attendance at this meeting by medical and nursing staff (night and day) from relevant areas.

The nursing handover on C1 Kendall was clear and well-structured and gave appropriate information regarding patients’ condition and risk assessments, any elevated warning scores, plan for admission or discharge and any outstanding treatment, tasks or test results. The AMU team used a structured template for handovers which were effective, thorough and gave opportunity for thorough discussion of patient needs, input and questions from all levels of staff was evident.

Medical patients were discussed at MDT meetings for cancer and other specialist services such as Neurology. Cancer MDT’s took place weekly and were cross site for each tumour site. Core membership included Consultants, Radiologists, Oncology, Clinical Nurse Specialists, Allied Health Professionals and MDT Coordinators. Where network links existed to other Trusts and organisations, the MDT takes place at the lead organisation with video links to NLaG.

Staff knew how to refer to mental health and alcohol teams when necessary.

**Seven-day services**

The General Medical Model for the Trust was that Monday - Friday 8 am to 5 pm, Acute Care Physicians provided cover and support for emergencies, the medial assessment units and caring for any new admissions through the emergency department and direct to ward. Monday - Friday 5 pm to 8 am, a General Physician was on call, with physical presence until 8 – 9 pm, depending on need. After this time, the Physician was on call from home.

Weekend arrangements were 8 am to 8 pm General Physician led on site and then continued to support off site, on call until the following morning. This provided cover and support for emergencies, the medical assessment units and caring for any new admissions through the emergency department and direct to ward.

In addition, at both sites, on weekends and bank holidays, a second medical consultant was available and responsible for discharging and providing routine support to ambulatory care and general support.

On C6 staff told us the locum gastro-enterologist did a daily ward round and then went to see outlying patients on B4.

A junior doctor on the AMU told us the team was responsive and patients received a consultant review very quickly. Therapy staff and social care staff worked in this area seven-days a week.

A trust wide audit of Clinical Standard 2 - Time to 1st Consultant Review in September 2017 showed that for the trust overall; the proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was 69% for weekdays and 68% at a weekend. A breakdown of medical specialities is detailed in the table below.

<table>
<thead>
<tr>
<th>Admitting specialty</th>
<th>Weekday Within 14 hours</th>
<th>Weekday Outside of 14 hours</th>
<th>Weekday Total</th>
<th>Weekend Within 14 hours</th>
<th>Weekend Outside of 14 hours</th>
<th>Weekend Total</th>
<th>Proportion reviewed within 14 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Internal Medicine</td>
<td>52</td>
<td>5</td>
<td>57</td>
<td>91%</td>
<td>20</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Cardiology</td>
<td>7</td>
<td>7</td>
<td>14</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes and Endocrinology</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>75%</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
Trust wide audits of; Time from admission to patient made aware of diagnosis, management plan and prognosis by day of the week was the same whether this was a weekday or at a weekend. Audit of documentation of the reason why the patient (and where appropriate families / carers) were not involved in discussions about the initial review within 48 hours of admission showed poor compliance but again showed no difference between weekend or weekday.

Staff told us about the weekend discharge team which was multi-disciplinary and commented that clear plans were left in place. The discharge team and consultant generally saw those patients ready for discharge only.

A pharmacy service is provided in SGH and DPOWH from 8.30am until 6.00pm on Monday to Friday and between 9.00am and 2.00pm at weekends and on Bank Holidays. An on-call pharmacy service is provided to each main site outside of these hours.

Occupational therapy was available Monday to Friday and a pilot was underway to provide occupational therapy support seven days a week in AMU / A&E.

Health promotion
We saw lots of health promotion information on the wards and around the hospital. For example, the information on the stroke unit included stopping smoking, local alcohol services, managing various conditions, carers support and falls prevention.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLS). DoLS can only be used if the person will be deprived of their liberty in a care home or hospital.

We looked at the trust's policies for consent and mental capacity act, including DoLS. We found that these were in date and contained appropriate references to legislation such as the mental capacity act, equality and diversity and the human rights act.

Most staff we spoke with had a good understanding of mental capacity and DoLS. They knew how and when to make DoLS applications and were aware of the need to ensure delirium had been
excluded before making a capacity assessment for a DoLS application. Staff knew who the safeguarding and other leads were and how to contact them if they needed support.

However, we saw two instances of poor recording of DoLS on C6, although it was clear emergency DoLS applications had been made, this was over seven days previously and it was unclear whether the DoLS had been reviewed and was no longer necessary or whether another application needed to be made. There were also two DNACPR records which were not signed on this ward.

We observed staff seeking verbal consent and patients told us that staff always asked permission before providing care and treatment.

We found that staff sought advice from other members of the ward MDT as well as the safeguarding and LD specialist nurses when difficult decisions needed to be made.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that Mental Capacity Act (MCA) training had been completed by 75% of staff and Deprivation of Liberty training had also been completed by 77% of staff within medicine at May 2018. However, medical staff compliance with MCA and DoLS training was poor at SGH with the exception of elderly medicine and cardiology who had over 85% compliance, the other services had 0% to 57% for DoLS training. Compliance with MCA training was mixed with compliance ranging from 33% in Gastroenterology to 100% in dermatology and elderly medicine.

The trust safeguarding lead told us that trust wide as of end of April: Mental Capacity Act (MCA) training was at 74%; DoLS training Level 1 was 77% and Level 2 was 56%. The trust was currently reviewing which staff need level 2 training for DoLS. MCA and DoLS training was delivered together with a focus on consent to treatment. Best Interest assessors within the trust had separate additional training.

The trust Safeguarding lead identified Level 3 training as a priority for the trust, together with making sure DoLS training is embedded.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 44% which was better than the England average of 25% from December 2016 to November 2017.

**Friends and family test – Response rate between 01/12/2016 to 30/11/2017 by site.**
Friends and family test – Medicine wards response (% recommended) - Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Ann. Perf.</td>
</tr>
<tr>
<td>AMETHYST WARD</td>
<td>134</td>
<td>21%</td>
<td>100% 95% 100% 100% 100% 100% 100% 100% 83%</td>
</tr>
<tr>
<td>AMU</td>
<td>819</td>
<td>67%</td>
<td>86% 92% 95% 97% 97% 92% 96% 98% 100% 97% 98% 100% 95%</td>
</tr>
<tr>
<td>C1 Hollies</td>
<td>444</td>
<td>69%</td>
<td>100% 92% 100% 100% 100% 100% 95% 100% 100% 100% 100% 100% 98% 99%</td>
</tr>
<tr>
<td>C1 KENDALL</td>
<td>271</td>
<td>45%</td>
<td>94% 91% 100% 86% 98% 91% 88% 100% 100% 92% 100% 100% 100% 95%</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>104</td>
<td>38%</td>
<td>87% 95% 100% 80% 100% 81%</td>
</tr>
<tr>
<td>Stroke Unit</td>
<td>138</td>
<td>28%</td>
<td>83% 100% 88% 100% 100% 86% 100% 100% 91% 100% 100% 95%</td>
</tr>
<tr>
<td>WARD C5</td>
<td>339</td>
<td>53%</td>
<td>93% 97% 100% 84% 95% 97% 100% 97% 100% 100% 100% 100% 97%</td>
</tr>
<tr>
<td>WARD C6</td>
<td>301</td>
<td>56%</td>
<td>100% 100% 87% 100% 100% 96% 100% 93% 100% 98% 97% 94% 97%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

We spoke with 12 patients on B4 and in the discharge lounge/ diagnostic interventions unit who were being discharged from a number of medical wards. Most patients described nursing staff as; caring, attentive, kind and explaining everything and updating patients regularly, despite being extremely busy. Two patients had had a number of admissions over a period of two to three years and spoke very highly of staff and services. Overall patients felt care from nurses and carers was very good.
We spoke with 13 patients and relatives on AMU who were very happy with the care and reported that they felt safe. They said communications with doctors and nurses was very good and they were complimentary about the standard of care.

We saw that the Cardiac Cath Lab had received 16 friends and family test responses and 15 were very likely and 1 likely to recommend. We saw that staff in this area informed patients of any delay or change to timing of appointments and apologised.

There were however a number of negative comments which included; a lack of doctors to give updates to patients/relatives and to facilitate discharge, not seen by a consultant on weekends, long waits in the discharge lounge, being moved at night and multiple moves.

We observed staff from all roles speaking to patients in a caring and courteous manner, displaying a genuine desire to help. We saw confused patients being cared for with kindness and compassion, providing distraction while keeping them safe.

We saw friends and family test feedback on ward C1 Kendall that showed a 100% recommendation rate from January 2018 to March 2018. There was you said we did information on this ward which showed staff had taken action to feedback that it was difficult to know which staff to speak to by designing an information board with designation of staff and uniform displayed. A patient who had been on this ward for a long time told us that they had been treated with kindness and respect by all members of staff.

We observed polite, professional interactions between staff on ward C5 and kindness displayed towards patients. However, we did see an incident on C5 where a patient was being walked down the corridor by a physiotherapist and their gown was open at the back.

Friends and family feedback was consistently positive and over 90% for C6. Positive feedback regarding individual staff was feedback to those individuals by the ward manager.

We heard therapy staff explaining discharge plans and equipment to a family member in a reassuring manner and in a way that was easy to understand.

The Amethyst ward undertook their own survey every month and asked ten patients to complete feedback forms. The latest results were displayed and showed that 100% of patients had said their needs were met. We spoke with 13 patients on Amethyst ward who all said the staff were lovely and caring, doctors were reported to have a good bedside manner and the whole team including the cleaners and ward clerk were friendly and the patient could have a laugh with them. Visiting was flexible and patients reported that all their needs were met quickly. Most patients felt they had full explanations of what was happening to them and why but three patients felt like they did not know what was going on. Patients said nothing was too much trouble for the nursing staff.

We saw that staff had implemented protected mealtimes in most areas and displayed patient experience feedback for all to see.

We saw staff dealing with challenging behaviour in a calm professional manner on C5 and treating all patients with kindness and respect.

On most occasions on all wards call bells were answered quickly.

We saw staff treating patients with respect and preserving their dignity, sometimes in very difficult circumstances. Patients felt staff were approachable and they could “have a laugh with them”.

**Emotional support**

Nurses worked with the Macmillan team to provide emotional support to patients with cancer.
We observed staff giving emotional support to patients who were anxious and frightened, using reassuring words and remaining calm.

**Understanding and involvement of patients and those close to them**

We heard patients being given clear instructions in a caring manner. We spoke with patients who had a good understanding and involvement in their plan of care.

A patient on C1 Kendall told us they and their family had been involved in care decisions and in We saw that conversations with patients and families, including questions and decision-making, were recorded in patient notes.

We observed a medical ward round on the AMU and saw the consultant was very patient, listening and answering all questions in a way the patient could understand. The patient was involved and asked about their opinion of additional investigations and onward referral.

Medical staff on the Cardiac Cath Lab had developed a patient information booklet in the form of word search and picture puzzles. This provided patient education on the structure of the heart and heart health and was developed to help give patients something to do while waiting. Staff had done this as they recognised wait times could sometimes be long, due to the nature of the procedures in the department.

The specialist nurses who supported patients with IBD provided education and had a helpline for patients to contact them, whenever they needed further information or support.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Average length of stay**

**Diana, Princess of Wales Hospital**

From December 2016 to November 2017 the average length of stay for medical elective patients at Diana, Princess of Wales Hospital was 6.3 days, which is higher than England average of 5.8 days. For medical non-elective patients, the average length of stay was 8.5 days, which is higher than England average of 6.5 days.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in rheumatology is lower than the England average.
- Average length of stay for elective patients in medical oncology is higher than the England average.

**Elective Average Length of Stay - Diana, Princess of Wales Hospital**
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

Meeting people’s individual needs

Admission forms did not cater for the recording of transgender or civil partnerships and we found that the religion section was rarely completed.

The stroke ward had a nearby gym where patients could undergo tailored therapy sessions and assessments prior to discharge. We saw that patients on the stroke ward were dressed to maintain their dignity and individuality. Call bells and drinks were mostly within easy reach of patients.

We saw from you said we did information on C5 that the ward staff had procured some foldaway beds to enable relatives to stay overnight with critically ill or end of life patients.
Patients with dementia or a learning disability were flagged on the trust electronic system using a specific icon, the icons could also identify if the patient had a person-centred care plan document 'My Life' for dementia patients or a ‘traffic light passport’, for people with a learning disability. We saw staff used 'My Life' documentation to facilitate person-centred care for patients with dementia and encouraged carers to be involved in planning and giving care where appropriate.

The trust had a full time Quality Matron with the strategic lead for dementia and learning disabilities across the trust and there was a full time Dementia Specialist Nurse and a part-time Learning Disability Specialist Nurse working at the hospital.

The Dementia Clinical Nurse Specialist was available to review patients in terms of nutritional and fluid intake, pressure areas, pain assessment (use of Abbey pain scale), falls risk and to support the nursing staff. They also reviewed medication and the use of sedatives and anti-psychotics. They support staff with capacity assessments, best interest decisions and DOLS.

The Learning Disability Liaison Nurse (LDLN) reviewed inpatients on the ward and discussed with them and their carers about their understanding of why they were in hospital and if any reasonable adjustments were needed to make the patient’s stay as comfortable as possible. The LDLN could complete a reasonable adjustment care plan and a hospital passport for any patient without one. They would also support staff with ensuring capacity assessments and best interest decisions were made and documented.

The specialist nurses were notified of all admissions through the IT system and could be contacted by phone/bleep if a ward needed immediate advice or wanted to request support. There was a prompt on the nursing admission for documentation for staff to contact the LD specialist nurse when an LD patient was admitted.

C5 had two bays which were refurbished with patients with dementia in mind, they had pictures and a clock with the date. All staff on this ward had received dementia training, there were signs above patients’ beds for preferred name and the bays had names rather than numbers.

We found on B4 that staff had created a bus stop with seats for dementia patients and they told us that this had been an effective way of calming agitated patients who were anxious or agitated especially if they were waiting for something or felt they needed to go somewhere. There was a desk and computer in each of the bays on this ward so staff could observe patients while writing up notes and carrying out administrative tasks.

Wards had rummage or memory boxes and twiddle muffs for dementia patients and we found that the staff we spoke with all had received training in caring for patients with dementia.

We saw staff used the ‘My Life Booklet’ and rummage/activity/reminiscence boxes and twiddle muffs were available for patients with dementia.

The hospital staff also had access to a mental health liaison team when they needed more specialist assessment and input into care and treatment for patients with dementia, a learning disability or mental health needs.

The quality matron for dementia and learning disability told us that dementia training was mandatory for all staff who come in to contact with patients. The training target for this training was 85% at tier 1 and tier 2 the achievement was 86% and 71% respectively at trust level. They told us that every ward has a dementia champion who attends a quarterly meeting led by dementia specialist nurse.
The trust provided the results of the 2017 patient led assessment of the care environment (PLACE) assessment. Patients gave this hospital an overall score of 60% for dementia care, this is improved from the previous score of 54% but is worse than the 2017 national average (76%).

The dementia lead told us that as the trust does not have dementia specific wards, this made environmental changes difficult. However, now all wards have plain curtains and dementia friendly signage. They told us that there was Board commitment to improve the wards to dementia friendly environments when refurbishment takes place.

The endoscopy unit had separate male and female recovery areas. Staff on endoscopy told us they would provide 1-1 nursing if a patient was confused.

There was a multi faith room for patient and relative use.

The Trust had the facilities in place to access interpreter services over the telephone. Staff were also able to request face-to-face interpreters. The service providers could translate documents into different languages when necessary. British Sign Language Interpretation was also available for patients who are deaf or hard of hearing. We saw communication aids in place for people who were hard of hearing. Staff we spoke with told us they could access support from interpreters when needed and information was available on the trust intranet. Endoscopy staff told us that interpreters were arranged by the booking office if a patient was coming in for a planned procedure.

We saw that TV was free for patients until 12 noon each day but needed to be paid for after that.

We saw that staff had adapted the times of antibiotic administration as much as possible while continuing an optimal regime, for a patient who had requested this to avoid being woken during the night.

We saw wards had pictures and staff uniforms displayed so patients knew who staff were and what designation they were.

The staff on C6 were hoping to be able to turn an unused bathroom into a dayroom for their patients.

Staff on Amethyst ward told us they could either make a referral to the Macmillan specialist cancer nurse or to the mental health team, to respond to a patient’s mental health needs. We saw that mental health needs were recorded in a patient’s medical history, although staff were not always fully aware of these needs.

Patients on the COPD pathway could access additional support regarding cognitive behavioural therapy, from specialist nurses and therapists. We saw individual needs were discussed on medical ward rounds when religious or cultural beliefs may impact on treatment options.

Access and flow

At this hospital elective patients were admitted directly to the wards or departments and non-elective patients were admitted through the emergency department (ED), or the Acute Medical Unit (AMU). The AMU had 32 beds and patients were assessed and stabilised here before being transferred to a ward. Staff told us the length of stay on AMU could range from 12 to 72 hours.

There was a 12-space ambulatory care unit next to the AMU that was open from 8 am until 8 pm Monday to Friday and 8.30am to 6 pm weekends. Staff actively sought appropriate patients from the emergency department (ED) and AMU as well as accepting referrals from GPs for assessment. Patients attended the ambulatory care unit to receive treatments on a day care basis rather than staying in hospital.
There was an escalation ward C2 which was opened when the hospital was full and needed additional beds. There was an escalation policy to follow should the hospital need the extra capacity. This was next to AMU and was staffed from green wards in the hospital. The ward was open during our inspection and could take up to 12 patients. Staff working in this area were one RN from a ward that was staffed at ‘green’ level and one bank or agency nurse, with a HCA. AMU tried to send lower acuity patients to this area and those waiting for discharge.

The endoscopy unit was open 7.30 am to 7 pm Monday to Saturday and lists were carried out between 8.30 am and 6 pm. There was a 24 hour on-call team of medical staff (consultant endoscopists), a nurse and healthcare assistant for gastro-intestinal bleeds across the two hospital sites and procedures were carried out in the main theatres out of hours. The ward clerk on the unit arranged for repeat or rearranged procedures and communicated with the GP surgeries regarding bookings and post procedure letters and information.

We found that the discharge lounge was being used at times to ease pressure on A&E, staff told us that occasionally patients who were ready to go home would be sent here to wait and on occasions patients waiting for beds may also be sent there. Staff told us patients were stabilised before they were sent to them and that they would order a proper bed for patients who needed one.

We were told that outliers were managed by using a ‘buddy system ‘which ensured they were seen by a doctor every day and that tests were initiated and results were reviewed. This did mean that the doctor seeing the medical outliers was not necessarily part of the patient’s consultant’s team and patients sometimes were transferred to a different consultant when they moved wards. Doctors told us of one patient who had moved medical team four times during their admission due to bed moves for non-clinical reasons and that handovers from one clinical team to another did not routinely happen when patients changed consultant.

We saw that all medical wards had a mix of patients which meant they were not always on the specialty ward relevant to their needs. We saw that this had been added to the risk register in September 2016 “Ensure that the designation of the specialty of some medical wards reflect the actual type of patients treated at Scunthorpe General Hospital and Diana, Princess of Wales Hospital and there were mitigations in place i.e. “Patient specific needs are currently identified by the Acute medical team and transferred to the appropriate wards. This is facilitated by the bed management team and intra ward transfers are undertaken if patient specific needs changes”. Although this risk had been reviewed regularly since it had been placed on the register there were no new updates. When asked the senior management team acknowledged that they had not thoroughly explored or quantified this issue and there were no plans to take specific action as the problem was tied up in bigger capacity issues. There were plans however, to change the function of one of the surgical wards to a medical ward which could improve this situation by increasing the capacity for medical patients.

WebV highlights length of stay using a traffic light system alerting managers/ matrons to ensure reviews have happened for long stay patients. Patients are highlighted as red when they have been in hospital for 10 days.

There were a number of patients on C1 Kendal waiting for a Percutaneous Coronary Intervention (PCI) without dates and one patient had been waiting several days due to a mix up with being listed for the procedure. Staff reported poor communication between the Cath Labs and wards regarding where patients will have their procedure (DPoW or SGH) and when they have been listed. ‘One patient was asked for at 15 minutes notice and another has waited a week and still doesn’t have a date’.

Staff on B4 told us that most patients arriving on their ward did not have a discharge plan in place when they came to the ward even though this was supposed to be a medical outlier ward.
Amethyst ward admitted patients from: the day case unit, from clinics such as the acute oncology nurse, from AMU and provided triage for patients receiving chemotherapy. The chemotherapy day case unit on Amethyst was staffed by four registered nurses, with staggered start times, to take account of patient flow through the day. The unit was open 8am to 6pm.

Staff on Amethyst told us that complex out of area discharges were sometimes delayed due to problems in arranging transport and gave an example of a delay getting a patient at the end of their life home.

A number of patients in the discharge lounge also felt they shouldn’t be told they can go home until everything was ready for them as they were becoming very frustrated at waiting in the discharge lounge for a number of hours for discharge letters, medicines or transport. One patient had left the discharge lounge and gone home without their papers as they were fed-up of waiting, another was threatening to go. One patient told us they had been told at 9am that they could go home at 9am, had come to the discharge lounge around 11am and were still waiting at 13.45.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From January 2017 to December 2017 the trusts performance has been stable but consistently worse than the England average.

In the most recent month, December 2017, the trust’s referral to treatment time (RTT) for admitted pathways for medicine showed 69% of this group of patients were treated within 18 weeks versus the England average of 89%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Two specialities were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>94.9%</td>
<td>93.2%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>62.5%</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moves per admission

The trust provided data on patient moves per admission for non-clinical reasons for each hospital site. However, they did not supply a break down at individual ward level and as such it should be noted that the figures below could include figures for both surgical and medical wards.

Diana, Princess of Wales Hospital:

During 2017, 92% of patients at Diana, Princess of Wales Hospital did not move wards during their admission, with 7% moving once or twice. Two hundred and twenty-five patients were moved three times or more. The number of bed moves was better than the previous year. Trust data showed that from January 2017 to December 2017 there were 308 patients moved at night at DPoW, ranging between 16 and 31 each month.

(Source: Trust Routine Provider Information Request - P51 – Bed moves)

Some staff told us that it was not unusual for patients to be moved late at night/early in the morning. There were two patients who also told us they had been moved multiple times.

Mixed Sex Accommodation Breaches

National guidance indicates that it is acceptable to have level two patients in mixed sex accommodation, however level 1 patients must not be mixed. There were 419 mixed sex accommodation breaches in the medical service at DPoW from June 2017 to January 2018. These breaches were recorded as being in the cardiology area.

Delayed Discharges

We looked at the trusts delayed discharge figures from February 2017 to January 2018. There were 841 reported delays for DPoW. However, we saw a decline in delays from February 2017 to January 2018 with the numbers falling from 89 in month one to around 65 in month 12 (with one peak of 91 in month 10).

Staff on CCU told us that delayed transfers of care could be due to waiting for discharge summaries, delayed transfer out of the CCU due to a lack of doctor availability, or delays in transferring patients to specialist beds at the tertiary centre.

DPoW had a discharge lounge which was open from 9am until 7pm Monday to Friday and 9am to 5pm weekends.

The trust employed patient flow or discharge coordinators. We spoke with a member of staff who
was part of the AMU team, who explained that part of their role was to assist in arranging the transfer of patients from the medical assessment unit to other wards and to facilitate discharge for medically fit patients. We were told that timely and safe discharges were a priority. To achieve this discharge coordinator liaised with patients’ families, social care teams, community nursing teams and care homes. If necessary, they were able to arrange home support and arrange equipment.

We attended a trust operational management meeting. These took place four times each day, these meeting were used to establish patient flow issues, staffing issues and the capacity and demand on each hospital site. The patient flow coordinator from AMU told us that delayed transfers of care were escalated at this meeting.

Staff at the trust told us that reasons for delayed discharges included funding issues for some patients out of area and sometimes nursing or care homes refused to take patients back when they felt they couldn’t meet a patient’s increased care needs. Transport could also be an issue, however there was also evidence of patients who were fast-tracked to ensure they were able to be at home if they were in the last days of life.

**Learning from complaints and concerns**

From February 2017 to February 2018, there were 115 complaints about medical care. The trust took an average of 52 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 30-45 working days, or 60 days for complex complaints. There were 62 complaints about medical services at DPoW.

A breakdown of the main subject of complaints in medical services is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>63</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>13</td>
</tr>
<tr>
<td>Communications</td>
<td>12</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>7</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>6</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>3</td>
</tr>
<tr>
<td>Appointments</td>
<td>3</td>
</tr>
<tr>
<td>(blank)</td>
<td>2</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>1</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We saw that patient liaison service leaflets, information on how to complain and patent feedback forms were available on the wards and departments.
Staff we spoke with displayed a good understanding of duty of candour.

**Compliments**

From February 2017 to January 2018, the trust reported 30 compliments for medical care being logged by a central team on the DATIX system. 15 of these were for Diana Princess of Wales Hospital, 13 were for Scunthorpe General Hospital and the final two were for Goole and District Hospital. Please note however, that any compliments sent directly to staff members are not logged using this system, therefore we are unable to know the exact number received by the trust.

The trust did not provide any additional information about these compliments; therefore, we are unable to comment on themes.

(Source: Routine Provider Information Request (RPIR) Compliments)

Positive patient feedback was displayed in some of the areas we visited

Is the service well-led?

**Leadership**

The medical service was led by a triumvirate of an associate divisional clinical director (DCD), associate chief operating officer and an associate chief nurse (ACH). The DCD and the ACN were both recently appointed to their roles. Staff spoke highly of the ACN, staff said they were accessible, approachable and listened to them. They said the ACN had responded to their emails, was supportive and keen for change / improvement.

The senior leaders were working to improve team working and share good practice / more effective ways of working across the hospital sites. They recognised that there were different ways of working at SGH and DPoW and each hospital had its strengths and weaknesses. They were aware of the difficulties they faced to encourage changes in practice to make services more streamlined and equitable in terms of quality and effectiveness.

The team told us they were aware the trust board had not always been fully supportive of implementation of difficult (agreed) change and told us they had been clear with the board that they needed their full support and backing when difficult choices / changes were made. The senior leaders felt that changes to the board of directors had been positive and that they had the board’s support.

We found that there was a clear leadership structure at clinical level. All wards had a ward manager who were supported by operational and quality matrons and the ACN. Staff we spoke with on AMU told us the matron was approachable and visible on the wards.

Matrons told us they would be starting to work clinically on the wards one day a month in a more planned way to provide more visible leadership and support. Currently the matrons did work clinically at times of pressure when the wards needed additional staff.

Ward managers had limited time to carry out their management duties as they were counted in the nursing numbers four days out of five. Some ward managers raised this as not being enough and had raised the possibility of being supervisory on the wards rather than counted in the numbers, but senior managers had not acted on this.
On C1 Kendall we saw ‘our story so far’ which showed the ward’s and staff’s progress from where they had been to where they were now and to where they wanted to go. Positive outcomes were shown as improved team work, improved morale and working towards improved outcomes for patients. Information regarding staff were proud of and what they were working towards / improve was on display on C1 and C6. The improvements highlighted on C6 included to improve fluid balance charts and for all staff to be trained to insert naso-gastric tubes.

On the stroke ward we found the ward to be noisy and chaotic with many staff of all disciplines at the nurses’ station having multiple conversations at once, including one nurse trying to do a shift handover to another nurse. There were also call bells ringing and patients calling out with HCAs rushing to try and meet their needs in the background.

On C5 we found that staff worked extremely hard but the ward felt short staffed and we saw the impact of this in patients being left unattended as staff had to leave an area to prevent a patient falling elsewhere on the ward, patients having to wait for call bells to be answered or calling out for several minutes before being seen to and having to wait inappropriate lengths of time for pain relieving medication. We saw that documentation was not always up to date and there were areas for improvement in communication between different staff. The ward manager had only been in post four weeks and they felt the ward was chaotic and needed a more structured day. They felt the matron and ACN were supportive with regard to change and improve services. A volunteer in the discharge lounge told us teamwork was brilliant, and staff morale was good. Staff on B4 said that teamwork was good and there was always someone to help.

The ward manager on C1 Holles was very proud of their team and how hard they worked. Aware that current ward badly in need of refurbishment and the plan in place to move to C2 in June and then to new ward area when works completed. Bank nurses on this ward enjoyed working here and found the team very supportive.

Staff on the AMU told us that morale had improved under new management (ward manager and matron), they now felt they could escalate concerns and would be listened to. A bank HCA told us that always tried to get shifts on AMU as it was a much better place to work over recent months.

The volunteer and ward clerk told us Amethyst was a good place to work and staff were friendly and supportive. The ward clerk had needed to provide cover to the surgical assessment unit over the last three weeks but this meant she had needed to ask others to cover her duties at times, they told us there had not been a ward clerks meeting since December and felt a little isolated from other admin staff because of this.

Feedback from staff regarding the leadership on all medical wards was positive and staff told us they were well supported by their line manager.

Matrons told us that ward managers held meetings for their staff. The matron would occasionally attend these meetings if there was particular feedback from incidents they wanted to share. Otherwise they attended these meetings on request from the ward managers.

Staff in most areas told us they were well-supported. Support staff and doctors on the AMU told us they felt valued and part of the team, they felt empowered and that managers were supportive. They told us they would not have any problems raising concerns.

**Vision and strategy**

The Trust was in the middle of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the medical service for 2018/2019 but we saw for 2017/2018 there was a business plan that covered SGH, DPoW and GDH. This took into consideration commissioning intentions and the strategic transformation plan objectives. There was an analysis of the strengths, weaknesses, opportunities and threats to the
service and several priorities for improvements and developments were tabled. We found that a number of the developments had taken place as planned such as; ‘SAFER red2green days’ process had been introduced at SGH and DPoW to highlight long stay patients with the aim of reducing unnecessarily long admissions.

For 2018/2019 the service had project plans and work was ongoing to embed or further develop across the trust; the medical model, the frailty service/pathway, ambulatory care and ‘SAFER red2green’. There was a draft strategy developed for the haematology service who were working in partnership with Hull and East Yorkshire Foundation Trust and the Queen’s centre to ensure sustainable service. The business and project plans did not cover all the specialities including cardiology which had been identified by the trust, during our interview with the triumvirate as a fragile service. However, A ‘Listening into Action’ event was planned for cardiology staff to look at how the service was to be taken forward and to develop a vision and strategy.

We found that ambulatory care had been introduced on the DPoW site which was now running seven days a week, the staff felt they were making a difference and alleviating some of the pressure on A&E and the AMU. They were aware was a business plan for the development of a dedicated Frailty Assessment Unit and pathway specifically targeted at older people, which would a more focused approach, reducing unnecessary admissions and reducing the average length of stay of older patients. It was planned that this unit would run alongside ambulatory care.

Senior nurses told us about plans to make cardiology an integrated unit with nine monitored beds and a 26-bedded unit all in the same area. Although staff on C1 Kendal were aware of the plans this was causing anxiety for staff who were concerned about where they would be working in the future and if it would be somewhere they would choose. Phase one of the work was due to start in June 2018 with the aim for the unit to be completed 2019/2020.

We saw special awards displayed on C5 for outstanding commitment from students/learners.

There was a trust wide staff retention strategy which focussed on delivering; culture transformation, instilling pride and belonging within the workforce, a review of reward and recognition incentives, staff wellbeing initiatives, staff engagement regarding quality improvement, career investment and looking at improving the work/life balance of all staff. We found evidence that the triumvirate were aware of this strategy and were working towards delivering the outcomes. We saw evidence that the DCD and ACN were working with staff to improve engagement and improve services. The ACN was a good role model regarding caring for staff and thereby improving care for patients.

The dementia lead told us there was a dementia strategy and plan and the trust had recently introduced a delirium policy and care plan as part of this. A local dementia steering group had been formed and was co-chaired with a member of the commissioning group. The trust was also working with the Humber Coast and Vale STP steering group. The dementia lead had a clear vision and focus for the next 12 months and understood the challenges to delivery.

**Culture**

During our inspection, we found staff were open and honest. They told us the culture on the wards was positive and they spoke about good team working. A RN on AMU described being nurtured.

All staff we spoke with told us they felt confident to approach their line managers if they were unhappy about something.

We spoke with the leadership team who told us they were aware that there was a feeling among some staff that there was still a legacy of bullying and intimidation in some areas of the trust and that they were actively trying to identify specific areas of concern and take action to improve this. There were some workshops planned for staff to take part in improving the culture of the trust. Staff were not aware of the trusts’ work around preventing bullying and harassment.
Staff we spoke with told us they were proud of their unit or service and their team members.

Some staff felt that nurses hadn’t had a loud enough voice at the trust but that this was improving and they weren’t afraid to speak out.
There were a small number of staff who had concerns regarding bullying and felt that some staff were afraid to speak out. They felt that some staff had left or were thinking of leaving because of the culture.

Health care assistants on the cardiac Cath Lab told us they felt well supported by nurses and medical staff and felt treated as an equal member of the team.

Registered nurses told us they felt that it put pressure on newly qualified staff when they were moved to a different ward, especially in their first six months at the trust.

There was a staff helpline number on the wall in the stroke ward for confidential advice regarding poor standards and behaviour.

**Governance**

The medicine group had a clear governance structure for acute and planned care. Governance structures were in place that provided assurance of oversight and performance against safety measures. We reviewed the quality and safety committee minutes and found discussion around current risks and performance. Information was discussed at these meetings from the different speciality groups.

The quality matrons completed observational audits to provide assurance that the appropriate care was being given to patients. These included; reviewing care records of the most vulnerable and the sickest patient on the ward, observing if patients looked cared for, how the ward felt, and patient / relative feedback.

A ward assurance tool the ‘Adult Nursing Audit Dashboard’ was in place that collated information from monthly audits. This looked at physiological observations, completion of risk assessments and other patient safety indicators. Results were reported as part of the nursing audit dashboard and identified areas for improvement or where support was needed.

Managers told us that the ward assurance tool process was being redeveloped as part of the Trust’s Improving Together and has now been approved by the Trust’s senior nursing team, the implementation roll out plan is currently being developed.

**Management of risk, issues and performance**

We reviewed the medicine risk register, which contained 61 risks. All risks had been reviewed several times throughout 2017 however many risks had little information in the way of updates and simply stated ‘risk reviewed, to remain on register’. For example, there was no recent comment or progress recorded for an action to pilot ‘a consultant of the week’ to ensure cardiology patients were reviewed daily on the AMU, this was to reduce the number of delayed treatments and discharges due to lack of specialist review. Although the pilot was due to end in September 2017 there was no update to the register entry which stated, ‘risk reviewed, to remain on register’. This did not assure us that actions regarding risks were effectively overseen or communicated to the reviewer.
Amethyst ward manager told us that issues on the risk register were; mixing of medical outliers and haematology / oncology patients in same bay. If this happened, it was flagged with the infection, protection and control nurse and logged as an incident.

The trust had a business continuity and strategy policy. This document contained details about how the trust would respond to an incident or event, which could disrupt services and contained details of the key individuals to support staff.

In addition, there was also a trust major incident plan. This was in date and contained appropriate guidance, contacts and level of escalation based on risk.

We spoke with the senior managers for the medical service who told us about their main concerns / risks, these included medical and nurse staffing and staff engagement / changing culture, compliance with training and remodelling of services/ pathways. Mitigating actions were explained, for example for staffing this included recruitment and retention plans / strategies, alternative staffing models and escalation plans.

**Information management**

Information provided by the trust, showed that 66% of trust medical staff and 84% of medical staff at DPoW had completed information governance training. Nursing staff compliance was 83% trust wide and 86% at DPoW. The trust target was 85% of all staff to have completed this training. We did not have any major concerns about the security of patients’ records at this inspection, although there were one or two areas for improvement.

Computers were available on medical wards; staff could access policies and clinical guidelines via the trusts intranet.

The trust had electronic systems in place for staff to request clinical tests for patients and view reports and x-rays.

Staff on Amethyst told us they were working towards implementing an electronic patient record and had been asked to give their input into the design of a new electronic care plan for oncology.

Staff told us that sometimes there was a delay between staff undertaking training and information being entered or pulling through on the Electronic Staff Record System (ESR).

**Engagement**

The trust provided details of senior management ward walkabouts and visits. Some, but not all, staff told us that they saw the executive team.

We saw that the ACN had held engagement events for; ward managers to develop objectives for nursing and for matrons to discuss their current role and vision for the future. Following the ward manager event, it had been agreed to hold a series of events over a year for staff nurses and HCA’s to look at their working day, the stressors, the celebrations and how they are feeling and how they can be engaged to enjoy their work.

Matrons and ward managers agreed a focus on 3 key areas; having a reputation within the group for being really good at fundamental nursing care, with a focus on NEWS / Care rounds / Sepsis; improving staff health and wellbeing and making education and training meaningful and up to date within clinical areas. Information was submitted to the wards to understand what these 3 areas meant to the ward staff, what would they want to see, how would they want to be involved?

The engagement activities demonstrated that the ACN was working to instil her view that ‘Caring for our patients is dependent on caring for our staff’. 
Staff in the Cardiac Cath Lab told us they had received late communications regarding services shifting to a hub and spoke model and remained uncertain regarding which services would be offered from each site. Staff in this area felt senior managers were not visible and that autonomy had been taken away from them regarding what procedures they could perform. They felt managers were not responding to their concerns and this impacted upon the planning of elective lists. It took a long time to fill vacancies and there were transport issues which needed resolving as this was often the cause of delayed discharges from the recovery area.

Staff on Amethyst ward told us they took part in regular staff meetings and daily handovers.

Staff told us C6 / endoscopy clinical leaders were visible and they felt valued working in endoscopy.

Staff told us they felt more needed to be done to retain staff and that more could be done to recognise excellence and innovation to improve services.

The service participated in the friends and family test and CQC Inpatient survey.

The trust participated in ‘Way Forward’ public engagement events in partnership with North East Lincolnshire Clinical Commissioning Group and other health and social care providers, to share their ideas about services for the years ahead. These events had been held at each of the three hospitals over the last 18 months and provided information about national, regional and local developments in health and care and the CCG’s commissioning intentions for 2018. The Trust gave information about the progress that had been made around improving quality, performance, finance and emergency care at Grimsby and Scunthorpe Hospitals. There was a choice of discussion groups for patients / the public to attend to look in more detail at specific health and social topics and have your say. A consultant from the haematology service facilitated one of the groups in March 2018. The CCG and Trust Patient Advice and Liaison teams were also at these events to listen to any complaints, compliments or any enquires about health and care services. Feedback from the events was mixed with attendees finding the sessions informative but not enough time to give opinions and suggestions, a feeling that service developments had already been decided and future sessions needed to be clearer about what the public could contribute. Members of the medical management team also attended the local health scrutiny meetings.

The gastro-enterology staff held a patient focus group every six months and feedback was shared at the endoscopy service user meeting. There was ‘you said’ ‘we did’ information displayed on the unit. The unit staff also told us that they undertook an annual patient satisfaction survey and the chief finding from the 2017 survey had been that 55% of patients had felt there no opportunity to discuss the procedure. The team was working to improve this and had also involved the patient participation group when improving the patient information leaflets.

Learning, continuous improvement and innovation

There were examples of innovation to improve services such as; the endoscopy unit had recently reapplied for JAG (Joint Advisory Group on Gastrointestinal endoscopy) accreditation in April 2018 and were waiting for final confirmation that this had been re-instated. There was a good system in place to ensure 2-week wait targets were met and urgent patients were seen quickly. There was joint working across the two hospital sites and patients could choose to have their endoscopy at SGH or at DPoW.

There was a 24-hour GI bleed rota in place across the two hospital sites and anaesthetic support was obtained from the general anaesthetist on-call rota.

We saw evidence of the effectiveness of the Frail Elderly Assessment Support Team (FEAST) team at SGH. This service was demonstrating positive outcomes and had been shown to be
reducing avoidable hospital admissions. Due to its success this model was to be rolled out at DPoW hospital.
Surgical services are provided at all three hospital sites, providing 228 beds and 10 high observation beds (HOBs) over 14 wards:

Diana, Princess of Wales Hospital has seven surgical wards. The surgery directorate provides acute, elective and day case surgery covering 10 surgical specialities. There are nine theatres, providing surgery in general surgery, breast, colorectal, upper gastro-intestinal, trauma and orthopaedics, ophthalmology, ENT, orthodontics, maxillofacial and urology specialties. There is one theatre dedicated to emergency surgery at all times.

(Source: Acute Routine Provider Information Request (RPIR) – AC1 Context)

The directorate has 137 beds, including six high observation beds (HOBs).

- Laurel ward – 17 beds
- Day surgery unit (B1)
- Ward B2 Surgical assessment unit – 26 beds, eight chairs
- Ward B3 – 20 beds plus six HOBs
- Ward B4 – 24 beds
- Ward B6 – 22 beds
- Ward B7 – 22 beds

(Source: Routine Provider Information Request (RPIR) – P2 Sites)

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

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

At the 2016 inspection, the trust target for mandatory training compliance was 95%; since the inspection the trust had lowered the compliance level to 85%. Current compliance rates for medical and dental staff was 58% and 77% for nursing staff, both rates were below the trust target of 85% and both rates had decreased from 2016 inspection compliance rate of 82%.

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses February 2017 to January 2018 for medical and dental staff by site is shown below:

Trust level

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The overall mandatory training completion rate for medical and dental staff in surgery was 58.7% at trust level, 58.2% at Diana, Princess of Wales Hospital. This was below the trust target of 85%.

At site level, the trust target was not met in any mandatory training module at Diana, Princess of Wales Hospital the target was not met in any of the 10 training modules.

A breakdown of compliance for mandatory courses February 2017 to January 2018 for qualified nursing and midwifery staff by site is shown below:

**Trust level**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>281</td>
<td>306</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>279</td>
<td>306</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>262</td>
<td>306</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>236</td>
<td>304</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>229</td>
<td>305</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>227</td>
<td>306</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>224</td>
<td>305</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>219</td>
<td>306</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>210</td>
<td>298</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The overall mandatory training completion rate for nursing and midwifery staff in surgery was 78.1% at trust level, 77.7% at Diana, Princess of Wales Hospital. This was below the trust target of 85%.

At site level, the trust target was met in three out of ten training modules at Diana, Princess of Wales Hospital.

(Source: Routine Provider Information Request (RPIR) – P40 – Statutory and Mandatory Training)

We saw that individual ward areas scored 67% for completion of mandatory training. Ward managers we spoke with said that due to staffing levels they found it difficult to release staff to attend training.

Mandatory training was completed either online or through classroom based training. The majority of staff that we spoke to had completed their mandatory training or were booked onto outstanding courses.

The trust had a monitoring system in place on the intranet which operated a traffic light system and sent staff and managers reminder emails when mandatory courses were due for renewal. All staff had a training matrix which showed them which courses they required and which were complete.

**Safeguarding**

At the 2016 inspection, the target level for safeguarding training was 95%. The training compliance level was 83% level one, 82% level two and 50% level three.

At this inspection, the target level for training had decreased to 85%.

A breakdown of compliance for safeguarding courses February 2017 to January 2018 for medical and dental staff by site is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>128</td>
<td>181</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>127</td>
<td>181</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>120</td>
<td>181</td>
<td>66%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Diana, Princess of Wales Hospital</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>60</td>
<td>88</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>60</td>
<td>88</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>56</td>
<td>88</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for medical and dental staff in surgery was 69.1% at trust level, 66.8% at Diana, Princess of Wales Hospital. This was below the trust target of 85%.

A breakdown of compliance for safeguarding courses February 2017 to January 2018 for nursing and midwifery staff by site is shown below:

**Trust level**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>258</td>
<td>306</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>252</td>
<td>306</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>251</td>
<td>321</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
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</tr>
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<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>139</td>
<td>161</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>134</td>
<td>161</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>125</td>
<td>161</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for nursing and midwifery staff in surgery was 81.6% at trust level, 82.4% at Diana, Princess of Wales Hospital, 77.2%. This was below the trust target of 85%.

The service had systems in place for the identification and management of adults and children at risk of abuse.
At this inspection, staff we spoke with said that they had completed adult and children’s safeguarding as part of their mandatory training. They also said that the trust safeguarding team was accessible and supportive when staff needed advice about safeguarding concerns.

The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse, and issues which staff should report. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern, and knew how to raise them.

Staff we spoke with could provide examples of safeguarding such as domestic abuse and pressure damage acquisition.

**Cleanliness, infection control and hygiene**

At this inspection, we found the wards and departments we visited visibly clean and tidy. We reviewed patient led assessments of the care environment (PLACE) reports for 2017 and noted 99% compliance for cleanliness better than the 98% England average.

The trust had an infection, prevention and control policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination and personal protective clothing.

Records we reviewed showed that not all staff had completed infection prevention and control training 45% of medical and dental staff and 73% nursing staff had completed training. This was below the trust trusts compliance target of 85%.

We saw information displayed on the wards and departments we visited celebrating the number of days since the last hospital acquired *Clostridium difficile* (C. *diff*) and Methicillin-resistant staphylococcus aureus (MRSA) isolate.

The directorate reported no cases of hospital acquired MRSA from April 2017 to March 2018. The trust reported no cases of *C. diff* in the same reporting period. This was lower than the trajectory of 21 cases, the agreed threshold for 2017/2018.

The trust had a policy to screen surgical patients for MRSA and some patients for methicillin-sensitive staphylococcus aureus as per best practice guidance.

The infection prevention and control team carried out surgical site infection surveillance data. The data we reviewed showed three patients had reported an infection following primary hip replacement surgery, out of 793 operations performed, this equates to a rate of 0.4% which is better than the national rate of 0.6%. Primary knee replacement surgery showed five patients had reported an infection following surgery, out of 814 operations performed, this equates to a rate of 0.6% which is similar to the national rate of 0.5%.

Quality matrons conducted monthly audits including the patient environment and infection, prevention and control. One ward manager showed us how the data was used to populate a ward dashboard. Another ward manager we spoke with was unable to show us their ward Infection prevention and control audits. Following the inspection, we requested to review these but despite request were not supplied with the audit to review. On ward B2 the ward manager had shared information from the audits with staff through a closed Facebook group and information sharing boards in the staff room. Staff highlighted concerns to us that the dashboards were useful, but they were unable to print them out to share with staff due to them being coloured charts and ward printers only being able to print black ink. Changes in practice had occurred as a result of the audits such as improved commode cleaning procedures and staff we spoke with were aware of the changes.

During the inspection, we observed that staff were compliant with hand hygiene policies, including ‘bare below the elbows’ and personal protective clothing policies.
Handwashing advice was clearly displayed and facilities for hand hygiene were available. Hand hygiene compliance data was displayed on wards we visited. We observed staff decontaminating their hands appropriately. Staff had access to at the point of use alcohol gel.

We inspected reusable equipment stored on the ward, and all items appeared to be visibly clean and ready for use. We observed staff cleaning and disinfecting equipment between patients, which followed the trust policy. We did not see that staff used a specific label to identify the equipment was clean and ready for use. We reviewed five pieces of reusable clinical equipment and found these to be clean but not labelled. We saw two pieces of equipment in theatres which were dusty and required cleaning, staff we reported this too cleaned them immediately.

Staff we spoke with said that they had access to appropriate personal protective clothing (PPE). We observed staff using gloves and aprons appropriately.

We saw processes for segregation of waste including clinical waste. Staff were able to segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment. Sharps bins in the areas visited were secure, dated signed and stored of the floor. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.

Rooms were available for patients requiring isolation, and during the inspection, patients requiring isolation were isolated appropriately.

Environment and equipment

At the 2016 inspection, we said the trust they should ensure that resuscitation equipment was regularly checked and tested consistently and in line with trust policy. At this inspection, we saw improved processes, all equipment we reviewed was clean, tidy, ready for use and staff had checked the equipment as per trust policy. Trolleys we inspected were locked, appropriately stocked and equipment was in date.

It is good practice to record and change airway breathing circuits on a daily basis (Association of Anaesthetists 2008), the theatre department used a checklist to record checking of anaesthetic machines, however the checklist did not reference the need to change the circuit so on the majority of occasions this information was not recorded from January to May 2018. There was also a number of gaps in the records which did not provide assurance that the machines had been checked on a daily basis.

The theatre warm fluids cabinet was showing as higher than the normal range during the inspection, this had the potential to provide fluids that were too warm for patient care, or to degrade the packaging of the fluids stored within the cabinet. We also saw that there was no record of when the fluids had been placed in the warm cabinet, despite the packaging stating that fluids should not be stored for longer than 60 days. We reported this to the nurse in charge of the unit.

Staff we spoke with said that they had adequate stocks of equipment and we saw evidence of stock rotation.

We looked at four pieces of equipment and found the majority to have been safety tested within the review date.

We reviewed patient led assessments of the care environment (PLACE) reports for 2017 and noted 94% compliance for condition, appearance and maintenance the same as the 94% England average.
We found that the domestic cupboard on wards B1 and cleaning cupboards in the sluice of B7 were unlocked; this room stored chemicals hazardous for health this could be harmful to patients or visitors who access this room by mistake.

Assessing and responding to patient risk

At the 2016 inspection, we said that the trust must ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist was implemented consistently within surgical services. During this inspection we saw improvements and it was clear that this had become embedded as a routine part of the surgical pathway.

We observed four occasions when the surgical checklist was in use, on all the occasions this was effective. We reviewed four sets of completed checklists in patient records and saw that these were completed appropriately at the time of the operation. We asked to review internal compliance data of the checks by the trust; this showed that the directorate scored 99.3%, 99.2% and 99.8% January to March 2018, slightly below the 100% compliance score.

Patient safety briefings were carried out pre-operatively these included introductions from the clinical team, the order of the list, additional equipment anticipated and the addition of emergency patients.

During this inspection, the trust used the national early warning score (NEWS) tool; the trust had been an early adopter of the NEWS two pathway to improve safety and clinical outcomes. Surgical areas recorded electronically the patient’s early warning score using handheld or static computers. Nursing staff escalated any patient of concern to medical staff. Nursing staff we spoke with could articulate the deteriorating patient and were able to describe when they would escalate to medical staff.

We reviewed four sets of medical records and we saw appropriate evidence of escalation. We asked to review internal compliance data of the checks by the trust, this showed that the directorate achieved 100% compliance in the audits September to November 2017.

At the 2016 inspection, we did not see that patients were assessed for surgery in accordance with effective pre-assessment pathways. At this inspection, we saw some improvements in surgical pathways, for example, patients now had access to a consultant anaesthetist review if required. Staff working within the directorate were aware of patients that had been listed for surgery without seeing them, or without carrying out all of the appropriate tests which had led to cancellations of their planned surgery on the day of admission. We also saw that many of the consultants had different pre-admission pathways, in regard to stopping anti-coagulation medicines. The pathways had not been formally agreed which had the potential to lead to difficulties within the pre-assessment team. For example, we asked three nurses working in pre-assessment the correct time to stop anti-coagulation medicines pre-operatively for the same clinical condition, and received three different answers. Staff we spoke with also said that patients could be cancelled due to not seeing the pre-assessment team at the correct time, for example to close to the date of surgery to allow the necessary tests to be carried out. Staff we spoke to also said that re-assess patients requiring surgery at different times for example to Scunthorpe pre-assessment team re-assessed patients at six weeks and the DPoW team re-assessed at 3 months. Staff also highlighted to us that the time of pre-assessment appointments had been shortened and additional staff had been instructed to take basic observations and recordings on patients, however this was causing difficulties for the pre-assessment nurses as it was leaving them with little time to carry out a full assessment. Staff had highlighted these issues to the senior management team. The changes needed more pace and a further period of embedding to provide assurance that the service was effective and responsive to clinical needs.
Staff we spoke with said that they had received sepsis training and staff we spoke with could articulate the signs of sepsis and were aware of actions required for escalation and treatment. We were not able to review any records of patients on sepsis pathways.

At the 2016 inspection, we said that the trust should ensure that patients are assessed for delirium in line with national guidance. At this inspection we saw 80% compliance (March 2018) with dementia assessments.

We reviewed risk assessments including pressure damage acquisition, malnutrition, falls, bed rails, moving and handling we found that on the majority of occasions these were completed. Where necessary staff had identified patients of high-risk and referred these patients to further services such as tissue viability teams or dietitians to provide additional support, equipment or assistance.

Venous thromboembolism VTE assessments we reviewed showed good levels of completion.

**Nurse staffing**

At the 2016 inspection, we said that the trust must ensure that there were at all times sufficient number (including junior doctors) of suitably skilled, qualified and experience staff in line with best practice and national guidance taking into account patients’ dependency levels.

At this inspection, we reviewed staffing fill rates for February 2018 and saw that the majority of shifts were scored above 85% for registered nurse (RN) shifts for both days and nights. No areas scored below 85%. The registered nursing fill rates for the areas were;

- Ward B2: 98% RN shifts days and 74% HCA shifts. Night shifts showed 96% RN shifts and 97% healthcare assistant (HCA) shifts.
- Ward B3: 98% RN shifts days and 74% HCA shifts. Night shifts showed 100% RN shifts and 95% HCA shifts.
- Ward B4: 85% RN shifts days and 97% HCA shifts. Night shifts showed 100% RN shifts and 100% HCA shifts.
- Ward B6/B7: 89% RN shifts days and 92% HCA shifts. Night shifts showed 98% RN shifts and 96% HCA shifts.

The trust reported their registered nursing and midwifery staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>129.1</td>
<td>126.4</td>
<td>132.23</td>
<td>123.28</td>
</tr>
<tr>
<td>Trust wide</td>
<td>7.52</td>
<td>8.52</td>
<td>7.52</td>
<td>8.72</td>
</tr>
</tbody>
</table>

The trust had a fill rate of 96.1% for nursing and midwifery staff in surgery in January 2018. For the previous year (January 2017) the trust had a nursing and midwifery staff fill rate of 93.3%.

We reviewed duty rotas over the last three months, and examined 189 shifts. Data showed that all areas were staffed below established levels on a small number of occasions, however the number of agency and bank staff used to achieve the planned staffing levels was high. For example,

- We reviewed 63 shifts on ward B2, 23 registered nurse shifts were below established...
levels, we were not able to review how many shifts had agency/bank staff in place.

- We reviewed 42 shifts on ward B7, three registered nurse shifts were below established levels, we were not able to review how many shifts had agency/bank staff in place.
- We reviewed 63 shifts on ward B3, 10 registered nurse shifts were staffed below established levels and 29 shift had bank and agency registered nurse allocated over this same period.
- We reviewed 14 shifts on ward B1, we saw no shifts staffed below established levels and no shifts where bank and agency staff were used.

The trust used the safer nursing care tool to monitor patients’ acuity and plan staffing levels, establishment reviews had recently been carried out and were awaiting approval at the trust management board. Staff escalated staffing issues through the site management meetings twice a day, these meetings were used to review activity, manage staffing issues and monitor capacity and demand on each site. The directorate used the SAFER (Senior review, All patients, Flow, Early discharge and Review) patient flow bundle, red2green initiatives and board rounds to improve safety and flow. The SAFER initiative involves five best practice safety elements to improve flow and discharge. The red2green campaign is a visual system to assist in the identification of wasted time in a patient’s journey, this approach identifies times patients spend in hospital without the day contributing to the patient’s discharge. The trust had recently employed a care navigator role to improve the patients journey and prevent or remove blockages in the patients discharge path.

Senior staff we spoke to said that retention of staff remained difficult, overseas recruitment was still occurring.

On the majority of occasions staffing levels in theatres were in line with the national recommendations for safe peri-operative care (AfPP) 2016.

Annual vacancy rates for nursing and midwifery staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>216.1</td>
<td>1,519.8</td>
<td>14.2%</td>
</tr>
<tr>
<td>Trustwide</td>
<td>-3.1</td>
<td>68.2</td>
<td>-4.6%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 15.5% for nursing and midwifery staff in surgery, which was above the trust’s target vacancy rate of 6.3%. Two sites did not meet the trust’s target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Annual turnover rates for nursing and midwifery staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>10.04</td>
<td>123.34</td>
<td>8.1%</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0.00</td>
<td>5.00</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
The trust had an annual turnover rate of 8.6% for nursing and midwifery staff in surgery, which was lower than the trust’s target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates for nursing and midwifery staff in surgery from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales</td>
<td>2,024.1</td>
<td>46,412.0</td>
<td>4.4%</td>
</tr>
<tr>
<td>Trustwide</td>
<td>0.0</td>
<td>1,779.0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 4.4% for nursing and midwifery staff in surgery, which was higher than the trust’s target of 4.1%. Diana, Princess of Wales Hospital did not meet the trust target for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The nursing bank and agency staff usage by site is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0</td>
<td>3,938</td>
<td>1,038</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>2,405</td>
<td>5,053</td>
<td>836</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0</td>
<td>2,801</td>
<td>521</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>1,248</td>
<td>3,372</td>
<td>519</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital

From February 2017 to January 2018 there was a total of 11,396 nursing shifts filled by bank or agency staff in surgery and 1,874 shifts remained unfilled.

At Diana, Princess of Wales Hospital there was a total of 7,421 nursing shifts filled by bank or agency staff in surgery and 1,040 shifts remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

At the 2016 inspection, we said that the trust must ensure that there were at all times sufficient number (including junior doctors) of suitably skilled, qualified and experience staff in line with best practice and national guidance taking into account patients’ dependency levels.

At this inspection, for all surgical specialities a consultant was present on site 8am till 5pm Monday to Friday.
On call cover was provided by junior doctors. Foundation level doctors were supported by middle grade doctors. Middle grade doctors were resident on-call. Staff we spoke with said that they were gaps in the medical rota; this was highlighted on the directorate’s risk register. The directorate had recognised that the failure to recruit substantive doctors had the potential to increase clinical and financial risks. In mitigation they had commenced weekly meetings to review medical staffing, partnership working agreements and more targeted recruitment. They had also increased the use of agency and locum staff within the directorate, however some gaps still occurred. The directorate also recognised that they had some fragile services due to being unable to recruit medical staff especially within urology, ear, nose and throat and trauma and orthopaedics.

The trust reported their medical and dental staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>82.76</td>
<td>84.59</td>
<td>75.51</td>
<td>77.47</td>
</tr>
</tbody>
</table>

The trust had a medical and dental staff over-establishment of 0.3% in surgery with two out of the three sites having more staff in post than planned. For the previous year (January 2017) the fill rate was 97.3%. Diana, Princess of Wales Hospital reported an over-establishment of 2.6% with more staff being in post than planned.

Annual vacancy rates for medical and dental staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>230.0</td>
<td>920.6</td>
<td>25.0%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 24.7% for medical and dental staff in surgery, which was above the trust’s target vacancy rate of 6.3%. All three sites did not meet the trust’s target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Annual turnover rates for medical and dental staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>5.91</td>
<td>52.19</td>
<td>11.3%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 9.0% for medical and dental staff in surgery, which was lower than the trust’s target of 9.4%. Diana, Princess of Wales Hospital did not meet the trust’s target for turnover rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Sickness rates for medical and dental staff in surgery from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales</td>
<td>599.6</td>
<td>19,252.4</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 2.6% for medical and dental staff in surgery, which was lower than the trust’s target of 4.1%.

The bank and agency staff usage by site is shown below:

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>694</td>
<td>1,786</td>
<td>14</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>162</td>
<td>935</td>
<td>11</td>
</tr>
</tbody>
</table>

The trust did not provide the total medical and dental shifts available, therefore bank and locum usage cannot be calculated.

In surgery, from February 2017 to January 2018, a total of 694 medical and dental shifts were filled by bank staff and 1,786 shifts were filled by locum staff. There were 14 shifts that remained unfilled.

*(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)*

As of October 2017, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average.

**Staffing skill mix for the whole time equivalent staff working at Northern Lincolnshire and Goole NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2
Junior medical staff we spoke with said that they felt supported working in the trust and felt able to raise concerns as required. They also said that they had appropriate training opportunities.

Formal medical handovers took place twice a day during shift changes, we observed one medical handover and found this to be well organised, well attended and relevant information was discussed.

**Records**

Paper records were available for each patient that attended the wards and departments; the trust used electronic patient management to record key information about the patient’s hospital stay. Electronic whiteboards were used on all wards we visited and these recorded key information about patient risks and treatment including flags for living with dementia, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Staff we spoke with said that they could access records out of hours with ease.

We reviewed fifteen sets of records during the inspection and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of review or administration of treatment. Patients records were all stored in areas that were secure, and in locked trolleys and we did not see any patients notes left unattended.

We saw that patient records held individualised plans of care; for example, pressure area prevention and falls care plans.

**Medicines**

At the 2016 inspection, we said that the trust must ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medicines are checked on a daily basis in line with the trust's policy. At this inspection, we saw that staff recorded medicines refrigerator temperatures daily. We also saw action recorded if the temperatures were not within expected ranges.

Pharmacy services were available seven days a week, with an on-call service available out of hours and on a Sunday.

We checked that medicines were stored securely including controlled drugs on wards we visited, on the majority of occasions. We saw controlled drugs were stored correctly with access restricted to authorised staff, they were checked in line with the policy and there were no discrepancies in controlled drug registers. Controlled drugs were audited by the nurse in charge of the ward on a weekly basis and checked on a quarterly basis by the pharmacy team. Following the inspection, the trust said that controlled drugs were now checked on a daily basis.

Following information received during the inspection, from a patient’s relative, we reviewed six medicine administrations charts on ward B6 and noted that on the majority of occasions medicines were not prescribed or administered in line with national guidance. For example, we saw a number of medicine issues including, patients being left unsupervised with medicines, individual medicines lockers being left unlocked, no indications for medicines on prescription chart, medicine doses not being prescribed, medicines being omitted on twenty-five occasions without reasons being documented, or omitted as not available on a further four occasions. We also saw medicines being administered on two occasions with no dates being documented.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers
follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

At the 2016 inspection, we said that the trust must ensure that, following serious incidents or never events, root cause and lessons learned are identified and shared with staff. At this inspection, we saw that from March 2017 to February 2018, the trust reported one incident classified as a never event for surgery. The never event was classified as a wrong implant/prosthesis and occurred at Diana, Princess of Wales Hospital in July 2015.

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with in theatres, said that they were aware of the never event, staff said that the trust shared information on the never event by briefings, newsletters and internal communication.

Serious incidents (SI) are incidents that require further investigation and reporting. In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from March 2017 to February 2018. Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with seven (23.3% of all incidents)
- Pressure ulcer meeting SI criteria with five (16.7% of all incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with five (16.7% of all incidents)

Site specific information can be found below:

- Diana, Princess of Wales Hospital: 20 incidents

(Source: Strategic Executive Information System (STEIS))

Ward managers we spoke with said that if a serious incident occurred they would be involved in the root cause analysis process. We reviewed three serious incident reports; we found these to
include contributing factors, identification of lessons learned and recommendations to prevent reoccurrence of the incident. Staff we spoke with on ward B2 could all explain when the last serious incident was and detailed changes in practice as a result of the incident for example improved neurological observation training.

The service had systems in place for reporting, monitoring and learning from incidents. The trust had an incidents policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents. The trust also had an electronic reporting system in place and staff we spoke with could describe how they would report incidents.

Staff we spoke with said that although there was a positive culture for reporting incidents they did not report all incidents, for example staffing or bed management issues.

Staff we spoke with were aware of the top three incidents for their areas including referral to treatment times, nursing and medical staffing issues.

Staff we spoke with said that the trust shared learning from incidents by staff meetings, shared through a file held in the sister’s office and via the intranet.

Safety huddles were used on all wards we visited, the senior management team said that these had improved communication and given increased structure to the working day. The safety huddles had recently been implemented and were used once a day to discuss the last 24 hours, the coming 24 hours, staffing concerns and ward incidents in the last 24 hours.

Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain examples of when they would use this. Duty of candour requirements were detailed in all the reports we reviewed.

Staff we spoke with were aware of the duty of candour regulations, they could provide us with examples of when they would use this such as nasogastric tube placement and wrong site surgery.

In the February performance report, we saw 100% compliance with duty of candour requirements.

For the surgical directorate we saw that the summary hospital level mortality indicator (SHIMI) and the hospital standardised mortality ratio (HSMR) were worse than target rates SHIMI 109 February 2018 and 106 March 2018 (target 95) and HSMR 110 February, 112 March 2018 (target 95). It wasn’t clear from meeting minutes we reviewed where this mortality data was discussed and used within the directorate or used to improve performance.

At the 2016 inspection, the directorate did not hold specific surgical mortality and morbidity meetings. At this inspection, the senior management team said that the mortality cases were reviewed, and within audit meeting minutes we saw that the process of review had changed. The new process involved peer reviewing of all patient deaths, identification of lessons to be learnt and discussion points. These cases would be discussed at the audit/mortality meetings. Within minutes we reviewed we saw that different processes occurred in different surgical specialities for example; orthopaedic teams had agreed to discuss all deaths however, ophthalmology had discussed removing mortality discussions from their agenda. The senior management team discussed with us that the process of discussion and sharing of learning from the reviews needed to be improved, and had commenced new processes to improve compliance and identification of lessons learned.

Safety thermometer
The safety thermometer is used to record the prevalence of patient harms and to provide
immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 62 new pressure ulcers, 16 falls with harm and 20 new urinary tract infections in patients with a catheter (CUTIs) from December 2016 to December 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Northern Lincolnshire and Goole NHS Foundation Trust

Prevalence rates of pressure ulcers remained similar over time except in September when a higher proportion of patients were reported to have a new pressure ulcer. Although prevalence rates of falls with harm and CUTIs varied over time, the numbers of reported incidents were low so any differences over time may not reflect changes in patient care.

(Source: NHS Digital)

During the inspection, we saw safety boards displayed on the wards we visited, these showed the results from the safety thermometer audits. These dashboards showed the number of pressure ulcers, fall and patient misidentifications. These were updated monthly.

The information on the dashboards was collected by sisters and other senior nursing staff. The data was discussed at team meetings but these weren’t held regularly.

Venous thrombolysis (blood clot) assessments were carried out in the trust and the trust data we reviewed showed the trust was currently not meeting the VTE assessment indicator with performance of 92%, this was lower than the trust agreed target of 95%.
Is the service effective?

Evidence-based care and treatment

At the 2016 inspection, we said that the trust must ensure that policies and guidelines in use within clinical areas were compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies. At this inspection we saw that 88% of policies February 2018 were compliant with NICE.

During this inspection, we reviewed some of the trust clinical protocols and patient pathways used for patients on surgical wards; these included hip fracture pathways. The clinical director discussed with us some pathways that had been changed and others that still required changing to improve patient experiences for example; changes to ear, nose and throat pathways, urology services and services now being delivered from a single site.

We saw that patients’ treatment was not always based on national guidance, such as the NICE, the Royal College of Anaesthetists and the Royal College of Surgeons. For example we saw that staff did not follow agreed protocols, pathways and best practice guidance especially in relation to access to theatres for patients with fractured neck of femur.

Policies were stored on the intranet and staff we spoke with could access them.

Wards and departments, we visited participated in local audit programmes called front line ownership audits. These audits had been developed to improve the patient experience and 10 criteria were reviewed on a monthly basis. These audits were also validated by the matron and infection, prevention and control team. Directorate data we reviewed for the month of April showed that three criteria scored red (less than 85%), four scored amber (between 85% and 95%) and 23 scored 95% or above.

The directorate held audit meetings where local surgical audit plans, were discussed. We reviewed seven sets of clinical audit meeting minutes and saw attendance from medical and audit staff and reviewing of the audit results.

Nutrition and hydration

We reviewed patient led assessments of the care environment (PLACE) reports for 2017 and noted 76% compliance for food and hydration which was worse than the 90% England average.

At this inspection, we saw that the majority of food and fluid charts were not always completed accurately. Staff did not total the daily intake and output on all fluid balance charts we reviewed.

Staff, by using the malnutrition universal screening tool (MUST) documentation, identified patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes. Patient records we reviewed showed good levels of completion. Staff also re-assessed patient’s nutritional status during the admission at regular intervals. We saw that nursing staff had assessed one patient as being at risk of malnutrition and had correctly referred the patient to a dietician.

Pre-admission information for patients provided them with clear instructions on fasting times for food and fluid prior to surgery. Current guidance recommends fasting from food for six hours and
fluid for two hours. Records we reviewed, showed that patients had adhered to fasting times prior to surgery going ahead. However; on three out of four occasions we did see that patients had fasted for too long for example between 12 to 18 hours prior to surgery. The directorate did not carry out audits on patient fasting times.

Protected mealtimes were promoted on the wards we visited. Red trays, were used to identify patients who required additional assistance with food or fluids.

We saw staff helping to re-position patients prior to their meal and assist them with their food.

The majority patients we spoke with said that the food was good and that the water was replenished daily and as required. One patient said that they had “lots of choice”, another patient said that “choices could be improved”.

Pain relief

During the inspection, we saw patients being offered pain relief. Patients we spoke with said that staff offered them pain relief at regular occasions and that staff checked that pain relief administered had been effective.

We observed staff using pain scoring tools to assess patients’ levels of pain; staff recorded this information on the electronic records system.

Some surgical patients received intravenous patient controlled pain relief post-operatively. This was in line with national best practice guidance from the British pain society.

The majority of patients we spoke with said that staff responded in a timely way, when they needed pain relief. Nursing staff we spoke with said that there was a trust pain team, to support patients in pain.

The post-operative anaesthetic care unit PACU, had recently begun auditing pain relief offered within PACU to improve pain relief assessments of pain relief and improve pain relief offered within PACU.

Patient outcomes

Trust level

From November 2016 to October 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

All of the top three elective specialties at the trust, based on count of activity (urology, colorectal surgery and ophthalmology), had a lower expected risk of readmission when compared to the England average.

All patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

All of the top three non-elective specialties at the trust, based on count of activity (general surgery, trauma and orthopaedics and urology), had a lower expected risk of readmission when compared to the England average.
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

Non-Elective Admissions – Trust Level

(Source: HES - Readmissions (01/11/2016 - 30/10/2017))

**Diana, Princess of Wales Hospital**

From November 2016 to October 2017, all patients at Diana, Princess of Wales Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

All of the top three elective specialties at the hospital, based on count of activity (urology, colorectal surgery and upper gastrointestinal surgery), had a lower expected risk of readmission when compared to the England average.

All patients at the hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

All of the top three non-elective specialties at the hospital, based on count of activity (general surgery, trauma and orthopaedics and colorectal surgery), had a lower expected risk of readmission when compared to the England average.

**Elective Admissions - Diana, Princess of Wales Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity
Non-Elective Admissions - *Diana, Princess of Wales Hospital*

![Bar chart showing comparison of hospital performance against England average across different specialties.](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*

*(Source: Hospital Episode Statistics)*

**Hip Fracture Audit**

*Diana, Princess of Wales Hospital*

In the 2017 National Hip Fracture Database audit, the risk-adjusted 30-day mortality rate was 6.6% which was within the expected range. The 2016 figure was 7.1%.

The proportion of patients having surgery on the day of or day after admission was 81.8%, which was in the top 25% of hospitals. The hospital did not meet the national aspirational standard of 85%. The 2016 figure was 74.1%.

The perioperative medical assessment rate was 84.5%, which was in the bottom 25% of hospitals and did not meet the national aspirational standard of 100%. The 2016 figure was 77.5%.

The proportion of patients not developing pressure ulcers was 89.7% which was in the bottom 25% of hospitals and did not meet the national aspirational standard of 100%. The 2016 figure was 96.0%.

The length of stay was 15 days which was in the top 25% of hospitals. The 2016 figure was 16.1 days.

At this inspection, we saw that although not meeting national aspirational standards, improvements had been made in proportion of patients having surgery on the day or the day after admission. We reviewed action plans, and noted areas for improvement, staff also highlighted to us that the recruitment of a fracture liaison nurse had improved the service and patient outcomes. Non-compliance with hip fracture audit and best practice recommendations was not highlighted on the risk register at the time of the inspection.

**Bowel Cancer Audit**

In the 2017 National Bowel Cancer Audit, 87.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 89%.

The risk-adjusted 90-day post-operative mortality rate was 4.5% which was within the expected range. The 2016 figure was 6.9%.

The risk-adjusted 2-year post-operative mortality rate was 23.9% which was within the expected range. The 2016 figure was 22.7%.
The risk-adjusted 30-day unplanned readmission rate was 10.5% which was within the expected range. This figure was not reported in 2016.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 63.2% which was worse than expected. The 2016 figure was 59.3%.

(Source: National Bowel Cancer Audit)

At this inspection, we reviewed action plans we saw that all actions had been completed in April 2018 and that issues of concern from the report had been identified and actions taken to improve performance.

Oesophago-Gastric Cancer National Audit

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.6%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 23.2%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.3% which was significantly lower than the England average.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

At this inspection, we reviewed the action plan for the trust and saw that the action plan addressed issues of poor performance within the report including the number of emergency admissions; 23.1% of patients diagnosed after an emergency admission compared to the national result of 13.7%. This was the second consecutive year that the trust had worse than national outcomes. The directorate had agreed an investigation of the cases diagnosed after admission to understand the reasons for this and to improve performance. The trust also performed worse than the national average for newly diagnosed oesophago-gastric cancer patients of OG cancer having a staging CT scan to enable the doctor to investigate the extent to which the disease has spread. directorate had agreed to review these patients and learn lessons to improve performance.

National Emergency Laparotomy Audit

Diana, Princess of Wales Hospital

In the 2017 National Emergency Laparotomy Audit (NELA), the hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death, indicating that between 50% and 80% of patients met this criteria. This was based on 94 cases.

The hospital achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames, indicating that between 50% and 80% of patients met this criteria. This was based on 70 cases.

The hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre, indicating that more than 80% of patients met this criteria. This was based on 51 cases.
The hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively, indicating that more than 80% of patients met this criteria. This was based on 36 cases.

The risk-adjusted 30-day mortality for the hospital was 9.3% which was within the expected range, based on 94 cases.

(Source: National Emergency Laparotomy Audit)

At this inspection, we requested to review the action plans for this audit, however, this was not supplied by the trust. Following the inspection, the trust supplied the action plan.

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was worse for EQ VAS outcomes and about the same for EQ-5D index outcomes.

For hip replacements and knee replacements was about the same as the England average.

(Source: NHS Digital)

At this inspection, we reviewed the directorate response to the results of the national audits and noted items of positive progress and items of concern from the audits were discussed at the quality and safety committee in March 2018.

Competent staff

From April 2017 to January 2018 65.7% of staff within surgery at the trust had received an appraisal compared to a trust target of 95%.
A split by site and staff group can be seen in the graph below:

### Trust level

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff who have received an appraisal</th>
<th>Total staff required to complete appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>5</td>
<td>5</td>
<td>95%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>102</td>
<td>133</td>
<td>95%</td>
<td>76.7%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>48</td>
<td>65</td>
<td>95%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>117</td>
<td>162</td>
<td>95%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>168</td>
<td>274</td>
<td>95%</td>
<td>61.3%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>99</td>
<td>177</td>
<td>95%</td>
<td>55.9%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>0</td>
<td>4</td>
<td>95%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff who have received an appraisal</th>
<th>Total staff required to complete appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>3</td>
<td>3</td>
<td>95%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>49</td>
<td>64</td>
<td>95%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>22</td>
<td>32</td>
<td>95%</td>
<td>68.8%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>58</td>
<td>87</td>
<td>95%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>89</td>
<td>146</td>
<td>95%</td>
<td>61.0%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>35</td>
<td>70</td>
<td>95%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>0</td>
<td>3</td>
<td>95%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital had a 63.2% appraisal completion rate overall for surgery with only qualified allied health professionals meeting the 95% appraisal completion target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

At this inspection, we saw a reduction in the appraisal rates reported for nursing and medical staff, however, staff we spoke with said they had, had a yearly appraisal. We saw individual areas had a 50% completion rate for achieved appraisals.

Senior staff we spoke with said that they had developed extended roles for nursing staff. These were nursing staff with extended skills to support patients. For example; advanced nurse practitioners staff had to complete additional training and competence qualifications to allow them to undertake these roles.

Within theatres, staff had specific roles with additional training to allow them to train other staff, for example; blood training, adult life support and specialist equipment training.
Newly recruited staff completed most of their mandatory training at an induction programme called ‘Care Camp’. This was an intensive two-weeks education programme to ensure that all staff received the same training and had been operating since 2015.

Registered staff we spoke with that they had been supported through revalidation by the trust.

We also saw a draft of the student nurse handbook for staff that were due on placement in PACU.

**Multidisciplinary working**

There was established multidisciplinary team (MDT) meetings for discussion of patients on specific pathways or with complex needs, this included attendance from consultants, specialist nurses and radiologists. We attended a multidisciplinary trauma and handover meeting and saw good attendance and appropriate discussion. We also saw that staff held joint MDT meetings with the local tertiary centre. Staff held multidisciplinary safety huddles on the wards we visited.

Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.

**Seven-day services**

The orthopaedic trauma list was delivered over seven days, this meant that patients who required surgery where able to access theatres in a timely manner.

At the time of the inspection, junior medical staff were available seven days a week with support from senior doctors and consultants. Surgical consultants provided a seven-day service.

Staff had access to therapy support seven days a week, however physiotherapy staff were only available on a Sunday to review unwell patients, or patients being discharged. A business case had been developed to provide orthopaedics with therapy staff seven days a week.

The trust pharmacy and diagnostic imaging department provided seven-day a week services.

The trust dietetic department offered a Monday to Friday service.

**Access to information**

Staff we spoke with us that they could access the trust’s policies through ‘The Hub’; i.e. the intranet.

Staff we spoke with said that they could access patient records out of hours by ringing the filing clerks to bring patient records on to the wards.

Staff we spoke with said test results could be access through the online patient management system. This was password protected and staff had different levels of access depending on their grades. Only doctors could access x-rays and scans through the system. Nursing staff could only access scan reports.

**Health promotion**

Health promotion information was available on all wards we visited. This included display boards and information leaflets. We saw information smoking cessation, healthy eating, drugs, alcohol and housing needs.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards. We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

The Mental Capacity act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, were someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests. Staff we spoke with could give a clear explanation of capacity assessment and the importance of recognising how ill health could impact on patients’ capacity. Staff also said that support was available from the safeguarding team if an urgent authorisation for a deprivation of liberty was needed for a patient who lacked capacity.

We spoke with nine members of staff across five surgical wards. All the staff were knowledgeable what they would do if a patient lacking capacity. Staff explained that mental capacity assessment would be conducted by trained staff on the ward. This would involve a two-stage assessment process including a memory test, if the patients were classed as high risk, an automatic alert was sent to the living with dementia team. However, during the inspection we did see one patient who lacked capacity and had not been consented correctly, pre-operatively. We discussed this with the ward and senior management team who carried out a root cause analysis and found that no specific alerts had been placed for this patient on the patient administration system or theatre booking system. They also found that the policy and guidance documents used for patients who lacked capacity required amending to ensure that the process for using the correct consent form was more robust.

At the 2016 inspection, we said that the trust must ensure that a patient’s capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the Mental Capacity Act (2015). At this inspection, we reviewed four records specifically for evidence of mental capacity assessments and we found this was completed in all four sets.

We also said that the trust should ensure that staff complete Mental Capacity Act training. At this inspection we saw that compliance was below the trust own target with 55% medical and dental staff and 77% of nursing staff completing training. Only one member of staff from nine we spoke with could confirm they had completed Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLs) training either as part of their mandatory training.

(Source: Trust Provider Information Request P14/P49)

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person’s best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are Deprivation of Liberty Safeguards (DoLs). DoLs can only be used if the person will be deprived of their liberty in a care home or a hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards. We only saw one patient with DoLs authorisations. We did see three patients with bed rails in place, that we could not find evidence of risk assessments or consideration of a DoLs application.

Staff we spoke with said they had access to mental health referral pathways and they would use these with any patients they had concerns about.

We saw that where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were stored at the front of the care records in line with national best practice. We did not see any ReSPECT documentation in use. ReSPECT is a process that creates personalised recommendation for a person’s clinical care in a future emergency in which the
patient is unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.

Is the service caring?

Compassionate care

We spoke with 37 patients on the surgical wards at this hospital. On the majority of occasions patients we spoke with were happy with their care.

In wards and departments we visited we observed staff caring for patients and found that they were compassionate and reassuring. We heard staff introducing themselves by name and explaining the care and treatment they were delivering.

Patients we spoke with said that staff were very caring and kind. On ward B1 we saw positive patient comments displayed, this included patients describing their care as “excellent” and describing the attitude of staff as “wonderful and caring” and “a lovely bunch of professional staff”. Another patient described the hospital as being “really good”. On ward B2 patients described staff “as fantastic” and “great”.

Patients we spoke with said that staff answered buzzers quickly and during the inspection we did not hear buzzers ringing for long periods of time.

We observed staff closing curtains and doors whilst delivering personal care.

Wards and departments, we visited displayed their friends and family results. The Friends and Family Test (FFT) response rate for surgery at Northern Lincolnshire and Goole NHS Foundation Trust from December 2016 to November 2017 was 23% which was worse than the England average of 29%. A breakdown of response rate by site can be viewed below.

Friends and family test response rate at Northern Lincolnshire and Goole NHS Foundation Trust, by site.
Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day cases</td>
<td>1607</td>
<td>5%</td>
<td>99% 99% 100% 98% 99% 100% 98% 99% 100% 99% 100% 99% 100% 99% 99% 100% 99%</td>
</tr>
<tr>
<td>LAUREL WARD</td>
<td>233</td>
<td>17%</td>
<td>87% 94% 100% 94% 100% 100% 100% 96% 100% 90% 100% 100% 97%</td>
</tr>
<tr>
<td>WARD B2 SAU</td>
<td>646</td>
<td>32%</td>
<td>98% 93% 91% 91% 95% 100% 97% 97% 100% 99% 97% 100% 100% 100% 100% 100% 97%</td>
</tr>
<tr>
<td>WARD B3</td>
<td>173</td>
<td>14%</td>
<td>100% 75% 100% 97% 93% 96% 100% 100% 100% 100% 100% 100% 97%</td>
</tr>
<tr>
<td>WARD B4</td>
<td>328</td>
<td>47%</td>
<td>90% 100% 96% 100% 94% 100% 98% 98% 97% 96% 100% 100% 97%</td>
</tr>
<tr>
<td>WARD B6</td>
<td>121</td>
<td>12%</td>
<td>100% 60% 100% 89% 100% 88% 100% 100% 67% 100% 100% 100% 92%</td>
</tr>
<tr>
<td>WARD B7</td>
<td>192</td>
<td>23%</td>
<td>100% 100% 100% 94% 100% 94% 100% 94% 100% 80% 100% 96% 96%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

**Emotional support**

We saw that ward managers were visible on wards and departments we visited, and patients and relatives could speak with them.

We heard a conversation between a patient and nursing staff and heard nursing staff providing comfort and support.
Patients we spoke with said that staff were available to talk to them as required. Patients we spoke with on wards B1 and B2 said that they had been “welcomed on to the wards and staff had been reassuring and kind”.

One patient spoke with us about being “worried about a family member” and a member of the nursing team phoning the relative to check on them.

Patients we spoke with said that staff were available to talk to them as required.

A multi-faith chaplaincy service was available for patients.

Clinical nurse specialists were available within surgery and attended wards to provide additional support and advice to patients.

**Understanding and involvement of patients and those close to them**

A range of information leaflets and advice posters were available on wards we visited. These included discharge information, specialist services and general advice about their care and treatment.

The majority of patients we spoke with said that medical staff took time to explain their care and the risks and benefits of treatment. Patients we spoke with said that they were aware of their plans of care and they had been given the time for questions and felt listened too.

Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions.

One patient spoke with us about the service accommodating their request for surgery on a specific date due to caring commitments, the service had ensured that the surgery occurred on the date planned.

Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The surgery directorate provided elective (planned) and non-elective (acute) surgical treatments for patients.

The directorate had improved collaborative working with commissioners and now had commissioners on key groups within the directorate to plan and deliver services.

**Meeting people’s individual needs**

At the 2016 inspection, we said the trust must monitor and address mixed sex accommodation breaches. At this inspection, NHS England had relaxed the requirements around mixed sex accommodation for all NHS providers to ease winter pressures. During this inspection, we did see male and female patients located next to each other in high observation areas. The trust said this was in agreement with commissioners.

Staff used ‘this is me’ documentation for patients living with learning disabilities. Patients living with dementia were identified to staff by a butterfly symbol to enable them to provide additional
support. We also saw hospital passports in use for a patient living with dementia to improve the patient experience and patient outcomes.

The trust employed a learning disabilities nurse; staff we spoke with knew how to access this service and said that this service was responsive.

We reviewed patient led assessments of the care environment (PLACE) reports for 2017 and noted 63% compliance for how well the needs of patients with dementia were met. This was worse than the 77% England average. Compliance was also worse 70% (83% England average) for how well the needs of patients with disability were met and compliance for privacy, dignity and wellbeing provision was 77%. This was worse than the 84% England average.

Patients we spoke with said that staff respected their privacy and dignity by closing curtains and doors as necessary.

The pre-assessment teams or the admitting wards identified patients' needs such as hearing, sight or language difficulties. Translation services were available for patients whose first language was not English. Staff we spoke with knew how to access these services. Staff we spoke with said this service was responsive.

Patients were provided with information leaflets on topics such as blood transfusion, Parkinson’s disease. The leaflets were in English and staff informed us they would contact Patient advice and liaison service PALS for leaflets in other languages.

Staff identified patients who had additional care needs at handovers and safety huddles, for example patients living with dementia, learning disabilities or mental health conditions.

Wards and departments were accessible for patients with limited mobility and people who use a wheelchair. Specialised equipment for bariatric patients was available on some wards visited.

**Access and flow**

At the 2016 inspection, we saw that the directorate did not have in place systems to ensure the capacity of services were sufficient to meet the demands. We saw that patients could not access services for assessment, diagnosis or treatment in a timely way. The service had long wait times and overall it did not meet referral to treatment pathways. At this inspection we saw worsening waiting times.

The service had started to identify capacity and demand for the service with the NHS Improvement intensive support team.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was generally slightly lower than the England average. Over the 12 month period the trust’s performance ranged from 61% to 69% and in the most recent month (December 2017) the 65% of patients were treated within 18 weeks from time of referral which was lower than the England average of 72%.

![Graph](This Trust vs England Avg.)
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of RTT rates for surgery broken down by specialty is below. Of these two specialties were above the England average:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>80.9%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>72.9%</td>
<td>64.5%</td>
</tr>
</tbody>
</table>

Four specialties were below the England average

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>70.1%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>61.1%</td>
<td>72.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>58.0%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>52.3%</td>
<td>61.4%</td>
</tr>
</tbody>
</table>

Trust Level – elective patients

From November 2016 to October 2017, the average length of stay for all elective patients at the trust was 3.5 days, which was similar to the England average of 3.9 days.

Two out of the top three specialties at the trust (based on count of activity) had an elective length of stay similar to the England average (trauma and orthopaedics and urology) and one specialty had a lower elective length of stay than the England average (colorectal surgery).

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

From November 2016 to October 2017, the average length of stay for all non-elective patients at the trust was 5.2 days, which was similar to the England average of 5 days.

Two out of the top three specialties at the trust (based on count of activity) had a higher non-
elective length of stay than the England average (general surgery and urology) and one specialty had a lower non-elective length of stay than the England average (trauma and orthopaedics).

**Non-Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>5.2</td>
<td>5.0</td>
</tr>
<tr>
<td>General Surgery</td>
<td>4.9</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>6.6</td>
<td>8.8</td>
</tr>
<tr>
<td>Urology</td>
<td>4.4</td>
<td>2.9</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

**Diana, Princess of Wales Hospital - elective patients**

From November 2016 to October 2017, the average length of stay for all elective patients at Diana, Princess of Wales Hospital was 3.5 days, which was similar to the England average of 3.9 days.

Two out of the top three specialties at the hospital (based on count of activity) had an elective length of stay similar to the England average (trauma and orthopaedics and urology) and one specialty had a lower elective length of stay than the England average (colorectal surgery).

**Elective Average Length of Stay - Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.5</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>4.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>5.6</td>
<td>7.1</td>
</tr>
<tr>
<td>Urology</td>
<td>2.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

**Diana, Princess of Wales Hospital - non-elective patients**

From November 2016 to October 2017, the average length of stay for all non-elective patients at Diana, Princess of Wales Hospital was 5.8 days, which was higher than the England average of 5 days.

Two out of the top three specialties at the hospital (based on count of activity) had a higher non-elective length of stay than the England average (general surgery and colorectal surgery) and one specialty had a lower non-elective length of stay than the England average (trauma and orthopaedics).

**Non-Elective Average Length of Stay - Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>2.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>2.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Urology</td>
<td>2.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>
We saw a worsening position in patients waiting longer than 52 weeks for surgical treatment. This had deteriorated from 135 patients in January 2018, to 324 patients March 2018.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From January 2016 to December 2017 the percentage of patients whose operation was cancelled and were not treated within 28 days increased over time, but in six out of eight quarters the trust performed better than the England average. In the most recent quarter (Q3 2017/18) 5% of patients whose operation was cancelled were not treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Northern Lincolnshire and Goole NHS Foundation Trust**

![](image)

**Cancelled Operations as a percentage of elective admissions - Northern Lincolnshire and Goole NHS Foundation Trust**

![](image)
From January 2016 to December 2017 the percentage of cancelled operations at the trust improved from Q3 2016/17 to Q4 2016/17 before deteriorating for the remaining reporting period. The trust generally performed similar to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

At the 2016 inspection, we saw that a high number of patients were cancelled for clinical and non-clinical reasons. Non-clinical cancellations were usually because of the lack of availability of surgical beds, cancellations for clinical reasons were usually because of in-effective pre-assessment of patients or patients had deteriorated pre-operatively. At this inspection we saw that within the directorate from January to April 2018, 318 patients had their surgery cancelled for non-clinical reasons, an average of 79 patients a month. A number of patients we spoke with said that they had had their previous dates for surgery cancelled and had to wait a few months for this to be rescheduled”.

We reviewed theatre usage and saw that out of 2,120 planned theatre sessions available within the directorate between January and April 2018, 1,992 sessions were delivered.

The directorate had recently opened an ambulatory care bay. Ambulatory care is used to assess and treat patients quickly, it helps to avoid unnecessary admissions and improves patient flow and experience. The directorate had also opened a surgical admissions lounge which enabled patients requiring surgery to be admitted to the lounge, go to theatre and then return to an appropriate bed on the ward. Staff we spoke with highlighted that this area often got converted in to an inpatient area, due times of increased demand. Staff reported that this caused confusion for community services as GP’s could not rely on the unit being open and able to accept referrals.

During the inspection, we saw a number of surgical wards had medical patients (outliers) located on them. The number of outliers affected the number of beds available for surgical patients. We also saw that a number of patients were cancelled on the day of surgery, due to availability of beds. Staff we spoke with said that they were frequently having to cancel patients due to a lack of availability of beds. The surgical management team recognised the issues of capacity and demand and balanced this with concerns over staffing levels. They had recently commenced bed modelling plans to ensure that services were delivered in an improved way. Some services had recently to only be provided on a single site to improve staffing levels and clinical outcomes. The management team recognised that this work needed to be extended to other services and include the provision of medical beds. Nursing staff we spoke with told us about their concerns relating to a lack of acceptance criteria, or risk assessment processes for medical patients outlying on surgical wards.

During the inspection we reviewed five patients’ admission details and noted that they had had between three to five ward moves during the admission. One patient had been moved five times over three days.

Staff working within the post anaesthetic care unit (PACU) talked to us about issues in relation to bed management and providing examples of times when patients had been allocated a bed on a ward, staff then transferred the patient to the ward and the ward bed was not available, leading to the patient having to be returned to the unit until another bed became available. Staff working in this area felt that improved communication between the matron and site co-ordination teams would avoid this.
We attended a patient flow meeting where we saw good discussion of patients due for admission, but didn’t hear any discussion of outlier patients, or any perceived risks from them being placed in outlier beds. We also did not hear any discussion on the number of days patients awaiting transfers to other wards or hospitals had waited. This did not provide full assurance that the risks of outlier patients had been fully assessed.

**Learning from complaints and concerns**

The trust had a process that addressed both formal and informal complaints that were raised by patients or relatives.

From 7 February 2017 to 7 February 2018 there were 131 complaints about surgery.

The trust took an average of 51 working days to investigate and close complaints. The trust had three targets for closing complaints. The trust had a target to close complaints within 30 working days and a further target of 45 working days. Only 24% of all closed complaints in surgery were closed in 30 working days and 34% of closed complaints were closed within 45 working days.

The trust had a target to close more complex complaints within 60 working days. Only 63% of all closed complaints (complex and non-complex) were closed within this target.

The most common subjects complained about in surgery were:

- Patient care - 68 complaints (51.9%)
- Appointments - 11 complaints (8.4%)
- Admissions and discharges (excluding delayed discharge due to absence of care package) - 11 complaints (8.4%)
- Communications - 11 complaints (8.4%)

**Diana, Princess of Wales Hospital**

From 7 February 2017 to 7 February 2018 there were 71 complaints about surgery at Diana, Princess of Wales Hospital.

The trust took an average of 53 working days to investigate and close complaints. Only 18% of all closed complaints in surgery were closed in 30 working days and 44% of closed complaints were closed within 45 working days.

Only 62% of all closed complaints (complex and non-complex) were closed within the target.

The most complained about subjects at this hospital for surgery were:

- Patient care – 38 complaints (53.5%)
- Admissions and discharges (excluding delayed discharge due to absence of care package) – 10 complaints (14.1%)
- Values and behaviours (staff) – seven complaints (9.9%)

We saw information displayed in ward areas about how to complain or raise a concern. Staff we spoke with could describe how they would respond to a compliant or a concern was raised.

Staff we spoke with said that themes and trends of complaints were shared with staff at ward huddles, meetings and individual conversations. The clinical director said that themes and trends of complaints were discussed at the directorate clinical governance meetings. We reviewed three sets of governance minutes and one set of governance oversight minutes and saw discussion about the numbers of complaints and concerns raised within the directorate.
Is the service well-led?

Leadership

In 2016 we saw that there had been a number of changes in the surgical senior management team and senior nurses within surgery had also changed roles and others were new in post. We said that these teams required further time to develop and become fully effective in their roles. Since the last inspection, the senior management team had undergone further changes and at the time of the inspection, one of the team was interim.

Over the last year the trust had changed divisional structures to improve clinical oversight and governance within directorates. The senior management team within surgery had been restructured, clinical directors had been appointed and had oversight of the directorate, they were supported by a divisional general manager and divisional head of nursing. Staff we spoke with said the senior management team was supportive and visible on the wards and departments, however; they also said that the executive team were not visible and “had not seen any directors”.

We found ward managers on the wards and departments we visited knowledgeable and professional. They appeared visible and approachable for junior members of staff they supported.

Ward managers were allocated dedicated time for management and support of staff, however due to staffing and skill mix ward managers were still expected to care for a cohort of patients whilst undertaking co-ordinator roles. This meant that ward manager had to prioritise work to enable patient care not to be compromised; this often led to them working additional hours or working in their free time to complete management tasks.

Junior medical staff said that they felt supported by senior colleagues.

Vision and strategy

The trust had a mission statement however this had not been developed in conjunction with staff and staff we spoke with were not able to articulate this statement, the strategic plan for the surgical directorate or the values of the trust. One member of staff we spoke with said that it was “working together”.

At the 2016 inspection, the clinical strategy did not refer to national reports and recommendations, the values or strategy of the trust or refer to appropriate deadlines for completion. At this inspection, we requested to review the strategy but despite request we were not able to review.

The directorate was reviewing different ways of delivering services due to recruitment issues. These included advanced nurse practitioners, advanced care practitioners and doctor assistants. Some of these staff had commenced training and some had yet to be agreed.

Culture

At the 2016 inspection, we said that the trust must ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions. At this inspection, staff we spoke with said that they had started to see improvements in the culture of the trust since changes in the trust’s leadership team.

Staff we talked with said they said they felt valued by their patients, ward leaders and the trust. They said that morale was variable within the wards and departments. One member of staff said
that they felt very lucky to have gained the position. However, another member of staff talked to us
about the bullying they had experienced whilst working in the surgical directorate.
The senior management team were proud of staff working within the directorate and their
resilience during ‘winter pressures.

Staff felt supported by their managers and colleagues at ward level. They said that ward managers
regularly “checked on how they were”. Staff we spoke with said that they had been aware of a
bullying culture previously, but since the change in executives they felt that this had improved.
Senior nursing staff we spoke with found some of the site management team unsupportive.

Governance
The directorate had changing governance structures. The clinical director was a member of the
trust management board and although a new structure, the management team felt that this had
improved communication within the directorate. The directorate had also set up a surgical
management board which was attended by all clinical leads and the senior management team
said this had a greater degree of clinical focus. Each speciality had business meetings which
escalated issues of concern to the overall surgical business meeting.

The current governance structures were in their infancy within the directorate and currently
provided low-levels of assurance against safety performance, from board to ward. The surgical
management team acknowledged that governance needed to be strengthened within the
directorate especially oversight of mortality, they also acknowledged that they required a further
period of embedding to be fully effective. We reviewed minutes from directorate transformation
board, governance committees, governance oversight boards and directorate board meetings
these did include some discussion about risk and incident themes and actions and business
updates. But these reports did not include issues for upward reporting or learning or evidence of
celebrating success and good news.

Management of risk, issues and performance
The trust had a business continuity plan. This document detailed how the trust would respond to
an incident or event, which disrupted services.

At the 2016 inspection, we said that the trust must ensure that service risk registers are regularly
reviewed, updated and included the majority of relevant risks to the service. The directorate had a
risk register which highlighted current risks and documented mitigating actions to reduce the risks.
Data we reviewed showed that there were currently 48 risks with 22 currently rated as high risks,
14 medium risks and 12 low risks following identification of mitigating actions. These risks were
reviewed at the monthly governance oversight meeting but in the minutes, we were supplied with
we did not see evidence of discussion or escalation of these risks to executive boards. The senior
management team spoke with us that these were new processes that required further time to be
fully embedded. Following the trust supplied further information providing assurance that
escalation if risks from the service were highlighted to the quality and safety board.

Following the inspection, the trust supplied further information providing assurance that escalation
of risks from the service were highlighted to the quality and safety board.

We discussed with senior staff within the directorate about their highest risks, they identified
staffing, performance, capacity, finance and pressure area management these risks were
identified on the risk register.

At the 2016 inspection, we did not see that the directorate had clear up to date recovery plans to
recover referral to treatment times. At this inspection, we saw that each speciality had
transformation plans including recovery and decisions had been made to provide services on one
site to improve patient safety and outcomes for example; ear nose and throat services, urology
services. Some transformation plans were still in their infancy and key actions, outcomes and mitigation had yet to be fully identified and developed. The surgical directorate transformation plans were based on the getting it right first time (GIRFT) methodology, this is a programme to improve efficiencies and clinical quality in the NHS, by reducing variations.

The directorate had not moved with pace to implement fully effective and consistent pre-assessment procedures. We did see some improvements in the service offered to patients in terms of increased capacity, staffing and educational developments but this required more embedding to be fully effective and responsive.

At the 2016 inspection, we highlighted that compliance with the number of patients with fractured neck of femurs receiving surgery on the day or the day after admission, at this inspection although not meeting the national aspirational standard we saw improvements. However, from discussion with staff working within the directorate that there was no clear oversight of the issues or sharing of issues that had improved performance at DPoW with Scunthorpe General hospital. Following the inspection, the senior management team said that the trust had improved oversight and now had daily updates on trauma numbers, re-instated the hip fracture governance meetings and had a commitment and drive to improve performance.

We saw variable performance in other national audits. Action plans we reviewed addressed issues identified within the reports, but had not had an impact on overall performance outcomes.

**Information management**

Information provided by the trust, showed that 80% of medical and dental staff and 95% of nursing staff had completed information governance training. Medical staff rates were worse than the trust’s target level of training of 85%, with nursing staff rates being above the 85%.

We did not have any concerns during the inspection about the security of patient records.

Computers were available on surgical wards. During the inspection, all computers were locked securely when not in use.

**Engagement**

At the 2016 inspection, we said the trust should review the formal feedback process in place to collect patient or relative feedback. We also said that the trust should take steps to improve its staff and public engagement activities. At this inspection, we saw that patient representatives were now included in key committees within the directorate.

During the inspection we saw “you said we did” display boards these showed changes of practice in relation to patient feedback for example; improved written communication pre-operatively.

Staff we spoke with said that changes in practice had been implemented as a result of patient feedback, these included reviewing fasting information for surgical patients.

Ward B7, had introduced a closed social media group to improve communication of the ward, staff we spoke with said that this helped to share key messages.

**Learning, continuous improvement and innovation**

The trust held a celebrating success award ceremony, a number of surgical staff had been nominated and won awards.

The trust was an early adopter of the National early warning scores NEWS two pathway, which provides improved safety and clinical outcomes for acutely ill patients.
It was clear that the staff working within the post-anaesthetic care unit (PACU), we committed to continually improving the patient outcomes and experience. They had led on a number of invitations including, improved pain relief post-operatively, safety briefings and improved patient handovers.

Maternity

Facts and data about this service

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of maternity services for women at all three of the acute hospital sites:

At Diana, Princess of Wales Hospital, Grimsby, maternity services are provided within a dedicated, custom made family services building. The service offered is an LDRP (Labour, Delivery, Recovery and Postnatal) system of care; which allows a woman to labour and deliver in the same ensuite room. The unit houses a dedicated operating theatre, a family room, a high dependency room, a room for disabled mums-to-be and a water-birth room.

At Scunthorpe General Hospital, Scunthorpe maternity services are provided on ward 26 and the Central Delivery Suite. Ward 26 is a mixed antenatal and postnatal ward where midwives provide care for women having inductions of labour, observations for complications and women resting following the birth of their baby. The ward also offers transitional care. The central delivery suite incorporates a dedicated obstetric theatre and has a birthing pool.

At Goole and District Hospital, Goole, the hospital offers daily antenatal midwife led clinics with a weekly obstetric clinic, there is also a midwifery led birthing suite onsite. The birthing suite is in within the grounds of the hospital though there are no other inpatient obstetric or neonatal services. Labour care is therefore provided to women booked for midwifery led care only in a ‘home away from home’ setting. The unit serves the East Riding area and has a delivery bed and birthing pool. Women who are classed as “high risk” are transferred to Scunthorpe for delivery.

The trust has 72 acute maternity beds located across six wards; four wards at Diana, Princess of Wales hospital and two at Scunthorpe General hospital.

Diana, Princess of Wales Hospital:
- Jasmine ward – nine beds
- Blueberry ward – nine beds
- Holly ward – nine beds
- Honeysuckle ward – ten beds

Scunthorpe General Hospital:
- Central delivery suite – eight beds
- Ward 26 – 27 beds

(Source: Trust Provider Information Request – Acute sites and context, Trust website)

From October 2016 to September 2017, there were 4,194 deliveries at the trust.
The graph below is the number of babies delivered at the trust in comparison with other trusts in England:

A profile of all deliveries and gestation periods from July 2016 to June 2017 can be seen in the tables below:

**Table 1: Profile of all deliveries (October 2016 to September 2017)**

<table>
<thead>
<tr>
<th></th>
<th>NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deliveries (n)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4,130</td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>64</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>240</td>
<td>5.7%</td>
</tr>
<tr>
<td>20-34</td>
<td>3,398</td>
<td>81.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>473</td>
<td>11.3%</td>
</tr>
<tr>
<td>40+</td>
<td>83</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Total number of deliveries</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,194</td>
<td>607,089</td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

Comparatively more woman under 20 years of age (5.7%) and between the ages of 20 and 34 years (81%) gave birth at the trust compared to England averages; 3.1% and 75.1% respectively.

**Table 2: Gestation periods (October 2016 to September 2017)**

<table>
<thead>
<tr>
<th></th>
<th>NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gestation periods</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Gestation period</th>
<th>Deliveries (n)</th>
<th>Deliveries (%)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
<td>*</td>
<td>0.2%</td>
</tr>
<tr>
<td>Pre-term 24-36 weeks</td>
<td>240</td>
<td>6.8%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>3,272</td>
<td>93.0%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
<td>*</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

**Total number of deliveries with a valid gestation period recorded**

| Total                  | 3,518          | 498,097        |

Notes: To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with *** (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

*(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)*

The gestation period of babies born at term (between 37 and 42 weeks) was 93.3%. This was above the England national average (91.8%).

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

*SOURCE: HES - Deliveries (October 2016 - September 2017)*

Data received from the trust showed that from April 2017 to March 2018, the home delivery rate for Diana Princess of Wales Hospital was 1.6% of total births across the locality. This was below the trust’s target of 2.2%.

For the same reporting period, the home delivery rate for Scunthorpe and Goole Hospitals was 2.2% of total births across the locality. This was within the trust’s target threshold (of 2.2% and higher).
Is the service safe?

**Mandatory training**

The trust set a target of 85% for completion of mandatory training. They were not meeting their target overall in both medical and nursing/midwifery staff groups.

The table below shows the trust wide, overall mandatory training completion rates (we received from the trust on 11 June 2018).

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>59%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>79%</td>
</tr>
</tbody>
</table>

The Governance midwife was responsible for coordinating the training of maternity services workforce across the trust; the ward managers managed the allocation of the mandatory training for their staff.

**Mandatory training completion rates**

A breakdown of compliance for mandatory courses from February 2017 to January 2018, for medical staff is shown below:

**Mandatory training - medical staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>12</td>
<td>15</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>11</td>
<td>15</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>10</td>
<td>15</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>9</td>
<td>15</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>9</td>
<td>15</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>8</td>
<td>15</td>
<td>53%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>7</td>
<td>15</td>
<td>47%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>5</td>
<td>15</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>4</td>
<td>15</td>
<td>27%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>90</td>
<td>150</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for medical staff in maternity was 60% at Diana, Princess of Wales Hospital. This was below the trust target of 85%. At site level, the trust target was not met in any mandatory training module except for information governance at Diana, Princess of Wales Hospital where 100% appliance was achieved.
Medical staff were individually responsible to book themselves onto the trust mandatory training and the Divisional Clinical director monitored this. The Governance midwife confirmed not all the medical staff were up to date with their training. They also provided evidence to show the staff were reminded to attend the training.

A breakdown of compliance for mandatory courses from February 2017 to January 2018, for qualified nursing and midwifery staff is shown below:

### Mandatory training - nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>121</td>
<td>126</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>109</td>
<td>126</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>104</td>
<td>122</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>106</td>
<td>126</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>101</td>
<td>126</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>99</td>
<td>126</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>97</td>
<td>126</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>91</td>
<td>126</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>77</td>
<td>126</td>
<td>61%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>75</td>
<td>126</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>980</strong></td>
<td><strong>1,256</strong></td>
<td><strong>78%</strong></td>
<td><strong>85%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for nursing and midwifery staff in maternity was 78% at Diana, Princess of Wales Hospital. This was below the trust target of 85%.

At site level, the trust target was met in three out of ten training modules at Diana, Princess of Wales Hospital.

(Source: Routine Provider Information Request (RPIR) - Mandatory training)

The ward managers managed their staff’s mandatory training. Staff were allocated to training as required, if they were unable to attend the session was rearranged. During the inspection one of the managers confirmed their involvement in having an overview and management of their staffs’ training.

A breakdown of compliance for mandatory training courses from February 2017 to January 2018, for qualified community midwifery staff teams are shown below:

### Community midwives:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>27</td>
<td>28</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Training Module</td>
<td>Participants</td>
<td>Required</td>
<td>Achieved</td>
<td>Target</td>
<td>Status</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------</td>
<td>----------</td>
<td>----------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>25</td>
<td>28</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>22</td>
<td>28</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>21</td>
<td>28</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>20</td>
<td>28</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>19</td>
<td>28</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>17</td>
<td>28</td>
<td>61%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>16</td>
<td>28</td>
<td>57%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>13</td>
<td>28</td>
<td>46%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>12</td>
<td>28</td>
<td>43%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>192</strong></td>
<td><strong>280</strong></td>
<td><strong>69%</strong></td>
<td><strong>85%</strong></td>
<td>No</td>
</tr>
</tbody>
</table>

The only training module to exceed the trust’s target rate of 85% was manual handling object (98%) and Equality and Diversity (89%).

Mandatory training information we received from the trust about the (Grimsby and Louth) community midwifery staff from February 2017 to January 2018, showed an overall compliance rate of 69%.

Information we received from the trust showed 44 out of 48 community midwives (92%) had completed infection control level 1 training in the previous financial year (April 2016 to April 2017). This equated to 23 out of 25 community midwives at this service (92%).

The trust provided updated mandatory training compliance data in March 2018, for maternity specific staff groups and by site. This showed the proportion of staff (across all grades and specialisms) that had completed maternity specific mandatory training modules (a maximum of 26 training courses) was 77% against a trust target of 85%.

Midwives working on the four obstetric inpatient wards achieved the following training compliance levels: 76% Blueberry/Holly team, 82% Jasmine/Honeysuckle team, 68% on the antenatal unit, 91% by the breast-feeding support staff, community midwifery teams achieved 65% and the labour ward coordinators achieved 81%.

Midwives, medical staff and healthcare assistants attended annual obstetric skills and drills training. Data provided by the trust in May 2018, showed compliance for skills and drills training across all sites was 81%. Site specific data was not provided and we did not have a trust target for this training. The training included antepartum, and post-partum haemorrhage, cord prolapse, eclampsia, shoulder dystocia, and vaginal breech. Compliance rates ranged from 80% to 83% for each emergency training module.

We spoke to the trust’s Governance midwife who explained that the figures did not include ad-hoc emergency study days; and if included, the compliance rate would be considerably higher.

During our inspection, we saw the obstetric emergency study day schedule for 2018. (The schedule was specific to this hospital.) The information included monthly dates for skills and drills training to December 2018. Staff confirmed they were able to arrange to have time to attend training.

Senior staff confirmed midwifery staff participated in obstetric Acute Life-threatening Events Recognition and Treatment (ALERT) training alongside medical staff, such as anesthetists and obstetricians. The training was a one-day multi-professional course to train staff in recognizing the...
deteriorating pregnant women and to act appropriately. Staff we spoke with told us the training took place annually. There was a requirement to complete training every four years.

Compliance for new born life support (NLS) training, for applicable staff within maternity services and across the trust locations was 70%.

Senior community midwifery staff told us all community midwives had received additional ‘baby lifeline’ training. This was focussed on childbirth emergencies in the community. An external provider facilitated the training. There were two cohorts of community midwives, and training had taken place in December 2017 and March 2018. The training was multidisciplinary and completed alongside ambulance crews.

Safeguarding

The trust had a safeguarding policy in place. There was an up to date domestic abuse policy (due for renewal May 2019). A named individual at the trust had oversight of the policy register. We looked at the register and saw appropriate actions were in place for maternity specific documents that had expired or were approaching their review date. (Please refer to the effective section, evidence based practice section of the report.)

The safeguarding lead for the trust told us within the safeguarding team there were two full time named nurses in child protection. There was also just under, two full time equivalent, named midwives (three members of staff, one for each site). Four days a week a named nurse for adults and specialised nurses (worked trust wide) supported the staff. There was also a trust level named nurse for the Mental Capacity Act (MCA) and /Deprivation of Liberty Safeguards (DoLS). The absence of this post was identified at the previous inspection and established.

At inspection, we found there was a safeguarding midwife in post at the hospital. They had protected time for monitoring and managing safeguard issues and enquiries. Safeguarding midwives attended child protection conferences and external multidisciplinary safeguarding meetings. The safeguarding lead for the trust told us that audits were currently being carried out to monitor staff attendance.

Staff we spoke with knew the safeguarding reporting procedures and safeguarding themes commonly encountered. For example, those centred on substance abuse and domestic violence.

Safeguarding training completion rates

The trust set a target of 85% for completion of mandatory training. They were not meeting their target overall in both medical and nursing/midwifery staff groups.

The overall safeguarding training completion rate for nursing and midwifery staff was 81% at Diana, Princess of Wales Hospital. Safeguarding level one training completion rate for this group of staff was 71%. They were below the trust target of 85%.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical staff is shown below:

Diana Prince of Wales Hospital:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The overall safeguarding training completion rate for medical staff in maternity at Diana, Princess of Wales Hospital was 68%. This was below the trust target of 85%.

Mandatory training for the medical staff was the responsibility of individuals to book themselves onto the trust mandatory training. The divisional clinical director monitored this.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018, for nursing and midwifery staff is shown below:

### Compliance for safeguarding courses

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>109</td>
<td>126</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>109</td>
<td>126</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>101</td>
<td>126</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>90</td>
<td>126</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Mandatory training)

A breakdown of compliance for safeguarding courses from February 2017 to January 2018, for community midwives are shown below:

### Community midwives:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>28</td>
<td>28</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>28</td>
<td>28</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>26</td>
<td>28</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>23</td>
<td>28</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for community midwifery staff was 93% at trust level.

The combined safeguarding training compliance rate was 94% among the community midwifery team. The completion targets for safeguarding children training (level 1, 2 and 3) were exceeded. The completion target for safeguarding adults training (level 1) fell slightly short at 82%.

Updated training figures received from the trust on the 11 June 2018, showed the overall safeguarding training completion rate for medical, nursing and midwifery staff was 83% at trust level, which fell slightly short of the trust’s target (85%). (These figures include adult level 1-3, children’s levels 1, 2 & 3 safeguarding training.)

**Cleanliness, infection control and hygiene**
Infection prevention training was part of the trusts’ mandatory training.

We observed hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks and hand gels were located at entrances and clinical areas with signs encouraging their use.

Personal protective equipment (PPE) was available in all areas we visited and provided to staff in the community.

All areas were visible clean. ‘I am clean’ stickers were seen on equipment and were dated and initialled, to show they were clean. Disposable curtains were dated, labelled and replaced every six months, or more frequently when stained.

We requested, but did not receive infection control audit data from the trust.

Single rooms were available for the isolation of patients, if needed.

There had been no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within maternity services at the trust in the last 12 months.

In the 2017 CQC maternity survey, the trust scored 9.0 out of a possible 10 for the cleanliness of rooms and wards; this was similar to the England average.

Environment and equipment

The trust provided audit data of monthly resuscitation trolley checks from March 2017 to March 2018. Data showed 100% compliance at trust level, for Diana Princess of Wales Hospital, and for Scunthorpe General Hospital over this period.

We inspected the infant resuscitative equipment cabinets in three patient rooms and found the equipment cupboards had been checked, restocked following use and the cupboards were sealed with a tag to indicate they were ready to use.

In line with the Home Birth Guidelines, (review date, November 2020) midwives had access to the equipment they would use for a home birth.

The service had a policy for the response in the event of a missing/abducted child/young person, the policy had an expiry date January 2019. There was equipment in place to monitor and alert if someone tried to remove a child from the service. The service did not have practice drill around an abducted child. Staff told us the drills was something they would include in future training. Community midwifery staff told us and we saw that they checked and signed each shift to show they had checked the equipment they had used, and were competent to use it. This included bariatric scales, and portable suction.

The sample of portable electrical equipment inspected across the service was all tested and in date with the exception of sonicade fetal dopplers (used for monitoring fetal heart rate). The same was found in the community. Staff in the hospital and community told us that the dopplers did not require electrical testing. All portable, electrical equipment should be tested in line with manufacturer’s instructions.

The trust provided data that showed eight sonicade dopplers held on the Acorn outpatient’s suite had been tested for ‘preventative maintenance’ from April 2016 to June 2017. An additional nine sonicade fetal dopplers held at the antenatal clinic were tested between January 2016 and January 2018. No additional data was provided and we were not aware of how many sonicades there were in total.
Assessing and responding to patient risk

Midwifery staff identified women at high risk by using an early warning assessment tool, known as the maternity early warning score (MEWS). This was to assess the health and wellbeing of women identified as being at risk. The assessment tool enabled staff to identify and respond with additional medical support where needed.

A review of the maternity service took place in June 2017, and included the CCG, Healthwatch and staff from the trust. Findings stated that notes reviewed by the clinical representative from the CCG did not provide assurance to recognise and escalate deteriorating patients appropriately.

As a result of the review, a MEWS action plan and update was submitted to the Directorate Governance Group every month. The plan listed 14 actions, the leads for each, timescale and evidence of completion. Most of the actions had been completed.

Weekly MEWS audit data from 02 January to 21 May 2018, showed appropriate clinical escalation, and 100% compliance from 10 April 2018.

Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in obstetric theatres an adaptation of the World Health Organisation (WHO) surgical safety checklist. The records we inspected contained completed checklists. Trust audit data showed from January to April 2018, 93% compliance across the trust and 92.8% compliance at this location for completion of the checklist.

NICE guidance recommends as a minimum, intrapartum fresh eyes evaluation and documentation every hour and by a ‘fresh pair of eyes’ every 2–4 hours (Intrapartum Care: Care of Healthy ‘Women and Their Babies During Labour. NICE Clinical Guideline 55).

Audit data provided by the trust showed from May 2017 to March 2018, there was 96.6% compliance with ‘intrapartum fresh eyes’ across maternity services at the trust. This hospital achieved 99.2% compliance in this period.

Swab count audit data provided by the trust included measures for swab counts for normal deliveries, for suturing, for instrumental deliveries, and for fetal blood sampling.

At trust level, data provided from March 2017 to March 2018 showed the following levels of compliance for swab count checks across the individual measures: 99.2% for normal deliveries, 98.8% for suturing, 99.4% for instrumental deliveries, and 95.1% for fetal blood sampling. Over the same period, data specific to this hospital showed the following levels of compliance for swab count checks across the individual measures: 99.6% for normal deliveries, 99.8% for suturing, 100% for instrumental deliveries, and 100% for fetal blood sampling.

The staff informed us they audited all sets of patients records each day. This included the surgical site infection (SSI) bundle, WHO check list-ward, anaesthetic room, theatre and recovery documentation. Where there were omissions in the records the member of staff responsible for the omission, was asked to retrospectively complete, time, date and sign the record.

Risk assessment at antenatal booking took place for all women to determine whether individuals were high or low risk.

There were processes in place in the event of maternal/baby transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.

Midwifery and nurse staffing
However, information gathered on site and provided by the trust suggested the service did not always meet required nursing and midwifery staffing levels.

**Planned vs actual**

The trust reported their registered nursing and midwifery staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>117.7</td>
<td>115.7</td>
<td>117.7</td>
<td>119.8</td>
</tr>
</tbody>
</table>

In January 2018, the trust had a nursing and midwifery staff fill rate of 98.9% in maternity, with 2.3 fewer WTE staff in post than the trust planned to provide safe and effective care. For the previous year (January 2017), the trust had a 1.0% over-establishment of nursing and midwifery staff with both sites reporting more staff in place than were planned.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From March to May 2018, we found 46 (2.7%) occasions in which planned numbers for nursing and midwifery staff were not met. From February to May the service reported 21 red flag events at this location. Red flag events are reported by the service when care or treatment such as induction of labour is delayed when there are not enough midwives available to provide safe care. Ten of the 21 red flag events (48%) were reported when staffing levels did not meet the planned levels; this occurred on seven individual occasions (multiple red flags were sometimes reported on more than one occasion). There was an additional midwife who worked between 08.00am and 16.00pm. The role of this midwife was to support with the triage of patients and the elective caesarean section list. We found this additional shift was not staffed on 19 (21%) occasions from March to May 2018; this equated to a fill rate of 79%.

**Vacancy rates**

Annual vacancy rates for nursing and midwifery staff in maternity from February 2017 to January 2018 are shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>28.3</td>
<td>1,087.2</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 3.2% for nursing and midwifery staff in maternity, which was below the trust’s target vacancy rate of 6.3%. This location met the trust's target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Annual turnover rates for nursing and midwifery staff in maternity from February 2017 to January 2018 are shown below, by site.
The trust had an annual turnover rate of 7.9% for nursing and midwifery staff in maternity, which was lower than the trust's target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Sickness rates for nursing and midwifery staff in maternity from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>1,830.0</td>
<td>30,539.3</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 6.9% for nursing and midwifery staff in maternity, which was higher than the trust’s target of 4.1%. This location did not meet the trust target for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From October 2017 to December 2017, the maternity staff sickness rate on Blueberry/Holly team ranged from 7.1% to 7.2%. The sickness rate had fallen back to within target level in January and February 2018. From November 2017 to February 2018, the sickness rate on Jasmine/Honeysuckle team ranged from 6.2% to 7.9%.

From October 2017 to February 2018, the sickness absence rate within the community midwifery team ranged from 4.6% to 6.8%. This was higher than the trust target of 4.1%.

Board meeting minutes, dated 27 March 2018, showed that nursing, midwifery and care staffing were discussed. The information stated sickness levels in the community midwifery needed to be monitored to ensure cover could be provided. The report did not specify which community midwifery team (if one in particular) this referred to.

**Bank and agency staff usage**

The nursing bank and agency staff usage from February 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0 (0.0%)</td>
<td>324 (94.5%)</td>
<td>7 (2.0%)</td>
<td>343</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>0 (0.0%)</td>
<td>841 (58.9%)</td>
<td>220 (15.4%)</td>
<td>1,429</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018 there was a total of 2,066 nursing shifts filled by bank or agency staff in maternity, which represented 53.8% of all available shifts, and 19.5% of all shifts remained unfilled.
At Diana, Princess of Wales Hospital there was 1,165 nursing shifts filled by bank staff in maternity, which represented 65.7% of all available shifts and 12.8% of all shifts, remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Midwife to birth ratio**

From October 2017 to September 2017, the trust had a ratio of one midwife to every 28.1 births. This was similar to the England average of one midwife to every 26.8 births. It was also an improvement on the trust’s performance in the previous period where from September 2015 to August 2016 there was one midwife to every 30.1 births.

(Source: Electronic Staff Records – EST Data Warehouse)

The Birth-rate plus classification of the midwife to birth ratio was that only the midwives in the current funded establishment should be counted; bank and agency staffing numbers should not be included in the calculations.

During our inspection we found the midwife to birth ratio across the trust was 1:28 against the establishment levels in March 2018. It ranged from 1:26.5 to 1:28 between April 2017 to March 2018. This was the same as the national minimum recommendation of 1:28.

However, at Diana Princess of Wales Hospital, the midwife to birth ratio was 1:30 (against establishment level) in March 2018. From March 2017 to March 2018, it ranged between 1:29 to 1:30. This was worse than the national minimum recommendation of 1:28.

We saw additional midwife to birth ratio figures at the location which included bank and agency staff (1:29 in March 2018,) and against an establishment level excluding staff on maternity and long-term sickness leave (1:31 in March 2018). Both measures were below the national recommendation of 1:28.

Data from May 2017 to April 2018 showed 84.5% of women received one-to-one care in labour at the trust. The proportion of women who received one-to-one care varied from 82.3% to 86.0% over the period. Site-specific information was not provided.

Data provided by the trust showed from April 2017 to March 2018, the average community caseload within the community teams was 135 women per midwife. The current recommended Birth-rate plus ratio, allowing for some changes in allowances and the NICE Guidance since 2009, is 96 cases per WTE midwife.

**Medical staffing**

**Planned vs actual**

The trust reported their medical and dental staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>12.2</td>
<td>11.5</td>
<td>12.4</td>
<td>13.5</td>
</tr>
</tbody>
</table>

In January 2018 the trust had a medical staff fill rate of 97.2% in maternity, with 0.8 fewer WTE staff in post than the trust planned to provide safe and effective care. For the previous year...
(January 2017) the trust had a staff fill rate of 98.3% with Diana, Princess of Wales Hospital reporting more staff in placed than were planned.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

Annual vacancy rates for medical and dental staff in maternity from February 2017 to January 2018 are shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>2.4</td>
<td>136.6</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 5.6% for medical staff in maternity. This was below the trust’s target vacancy rate of 6.3%. Diana, Princess of Wales Hospital was the only site to meet the trust’s target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Annual turnover rates for medical and dental staff in maternity from February 2017 to January 2018 are shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>0</td>
<td>4.25</td>
<td>0%</td>
</tr>
<tr>
<td>Trust total</td>
<td>0.59</td>
<td>6.37</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 4.6% for medical staff in maternity, which was lower than the trust’s target of 9.4%. Diana, Princess of Wales and Scunthorpe General hospitals met the trust’s turnover target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Sickness rates for medical and dental staff in maternity from January 2017 to December 2017 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>21.6</td>
<td>1,527.7</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 0.7% for medical staff in maternity. This was lower than the trust’s target of 4.1%. Diana, Princess of Wales met the trust sickness target.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and locum staff usage

The medical bank and agency staff usage from February 2017 to January 2018 by site is shown below:

Trust level:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>222</td>
<td>305</td>
<td>9</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>145</td>
<td>219</td>
<td>0</td>
</tr>
</tbody>
</table>

The trust did not provide the total medical shifts available; therefore, bank and locum usage cannot be calculated.

In maternity, from February 2017 to January 2018, a total of 222 medical shifts were filled by bank staff; 305 shifts were filled by locum staff. There were nine shifts that remained unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

In December 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 45.1 whole time equivalent staff working in maternity at Northern Lincolnshire and Goole NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>32%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>19%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>35%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>13%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

There were six consultants employed at this location. However, due to clinical concerns one consultant was not practising on the labour ward. This meant five consultants were undertaking labour ward cover and on the on-call rota for six.
The trust reported a labour ward consultant cover of 60hrs per week; this was in line with the recommendations of Safer Childbirth (2007). However, consultants were undertaking labour ward cover as well as working in the antenatal clinics. This meant a consultant might be called to an emergency on labour ward whilst seeing a patient in the antenatal clinic; this could reduce the continuity of care. The consultant body were already working on reduced consultant numbers as mentioned above and this further impacted the provision of 60hr cover.

These practices were not following the trust’s ‘Policy for safe Staffing Levels for Obstetricians, Midwifery and Support Staff’ (version 2.2, issued 08 May 2018, p6). The policy stated that, “currently there are six consultants at Grimsby … who are present to cover the labour floor with no other duties for 60 hours per week”.

**Records**

We saw secure storage facilities for paper records at this hospital. Electronic records were also kept, and procedures for safe storage were in line with data protection requirements. Handheld notes were carried by women throughout pregnancy, in line with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) statement 3.

In March 2018, as part of their audit programme the trust re-audited multidisciplinary records of women using the service. At the time of viewing, the report was in draft format and had not been presented to the audit meeting or the Obstetrics & Gynaecology Governance Group and an action plan had not yet been produced.

The results of the audit were encouraging with a number of standards achieving over 90% compliance. However, issues were also identified.

We inspected 14 sets of records at the inspection and found general record keeping was of a good standard. Records showed good practice where the midwife countersigned a student’s entry in the records; in line with the Nursing and Midwifery Council (NMC) guidelines.

**Medicines**

Staff had access to up to date electronic medicine policy guidelines via the trust intranet and the trust pharmacist visited the wards and departments weekly.

The community midwives ordered their stock medicines from the pharmacy and were securely transported to their community base.

The storage and checking of medicines, including the medicines refrigerator temperatures were taking place. Controlled drugs were checked twice daily and recorded in the appropriate book.

We reviewed eight prescription charts. Three of the records did not include the prescribing doctor’s printed signature, bleep number or General Medical Council (GMC) number. For audit purposes it would be difficult to identify the prescribing clinicians.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From March 2017 to February 2018, the trust reported one incident which was classified as never events for maternity.

This was recorded as a maternity/obstetric incident meeting serious incident criteria: mother only, and referred to a retained foreign object (a swab) post procedure which occurred in May 2017 at Diana, Princess of Wales Hospital.

(Source: Strategic Executive Information System (STEIS))

Monitoring of the action plan from the incident was shown in the Obstetrics & Gynaecology Clinical Governance meeting minutes from 26 January 2018. We also saw evidence that active monitoring of the progress of the action plan took place.

Staff were aware of the incident, the changes in practice and the learning taken place. This included all staff watching a training video and signing to show they had completed it.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2017 to February 2018.

A breakdown of the incident types is shown below:

- Seven maternity/obstetric incident meeting SI criteria: mother only (59% of total incidents).
- Three maternity/obstetric incident meeting SI criteria: baby only (this include fetus, neonate and infant) (25% of total incidents).
- One abuse/alleged abuse of adult patient by staff (8% of total incidents).
- One sub-optimal care of the deteriorating patient meeting SI criteria (8% of total incidents).

Seven of the 12 incidents occurred at Diana, Princess of Wales Hospital, four at Scunthorpe General Hospital and one was reported in the community.

(Source: Strategic Executive Information System (STEIS).

The service reported a cluster of eight serious incidents six of which took place at DPoW hospital between October 2017 February 2018. The main theme identified regarded bladder care, all staff we spoke with informed us there had been an increased focus on the completion of fluid balance charts and identification of bladder concerns.

The trust had a policy for reporting incidents, near misses and adverse events in maternity services. Staff we spoke with said they were encouraged to report incidents and were aware of the process to do so.

Staff reported incidents on the trust’s electronic incident-reporting system. We reviewed four root cause analysis (RCA) reports and associated actions plans. We found the structure had improved since our previous inspection in 2016 and clearly identified the root cause of the incident. Following investigations staff told us of what had occurred and learning from the incidents. The service used internal communication methods to inform staff of learning and changes to practice (for example, the weekly learning memorandum from the interim head of midwifery). We found highlights posted on staff notice boards and minutes of meetings where staff signed to show they were aware of the information.

The Duty of Candour (DoC) is a legal duty for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that had led to moderate or significant harm. Staff we spoke with could discuss the principles of duty of candour and gave
examples of when it applied. We found evidence of DoC discussions when reviewing root cause analysis reports. The staff we spoke with said they were open and honest with women if things went wrong.

**Safety thermometer**

During our 2016 inspection, we recommended the trust begin to upload data to the maternity safety thermometer. The trust had submitted this data since January 2017.

The Maternity Safety Thermometer is used to record the frequency of patient harms. It is used to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

The graphs below identify the levels of harm free care for the maternity service.

![Graph of Harm Free Care](image)

![Graph of Women's Perception of Safety](image)
The graphs show mixed results for the perception of harm free care for the service. However, women reported feeling safe 100% of the time between August 2017 and February 2018.

**Is the service effective?**

**Evidence-based care and treatment**

The delivery of care and treatment was based on guidance issued by professional and expert bodies. This included the National Institute for Clinical Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), Nursing and Midwifery Council (NMC), and evidence based practice.

Local policies, procedures and clinical guidance were accessible on the trust internet site, which staff found easy to navigate. We checked 16 policies; with the exception of two, which were being reviewed, they were current and reflected quality standards and national guidance.

During the inspection, we saw a centrally held document control register. The register listed all trust policies and clinical guidelines; alongside version controls, review dates, and the different stages of review (where applicable). A named individual at the trust had oversight of the register. The governance midwife informed us that a maternity specific document register was emailed to them each month. From this, they were able to have oversight of documents approaching a review date and take necessary action to ensure they were reviewed and revised.

We looked at the maternity specific document register. We saw appropriate actions were in place for documents that had expired or were approaching their review date. For example, named individual staff were listed against policies currently being reviewed together with a date for submission for approval.

**Nutrition and hydration**

There was a specialist infant feeding coordinator. They led on the implementation and training associated with the United Nations Children’s Fund (UNICEF) Baby Friendly Initiative (BFI) standards.

The UNICEF initiative is a worldwide programme that encourages maternity hospitals to support women to breastfeed.

UNICEF BFI professional officers inspected in October 2017 and re accredited the service with full UNICEF baby friendly accreditation, level 2.
The trust-wide breastfeeding initiation rates for deliveries that took place in hospital from March 2017 to April 2018, showed an average of 68.2%. This was lower than the trust's target rate of 74.4% and same as the Yorkshire and Humber average of 68.2%.

The maternity dashboard figures for Diana Princess of Wales Hospital showed an average breastfeeding initiation rate of 59.3% from April 2017 to March 2018.

There was a dedicated infant feeding team with a remit to provide support services across the locality. The service was open to referrals from any health and social care professional, and women could self-refer. There was an infant feeding lead in post for Diana Princess of Wales Hospital. Infant feeding team members provided support for mothers in hospital and community settings, and in women's own homes.

**Pain relief**

Women received detailed information of the pain relief options available to them, this included Entonox piped directly into all delivery rooms, and pharmacological methods such as Diamorphine.

All the women we spoke with said they were able to access pain relief in a timely way, analgesia was offered regularly and their pain was well managed.

Anaesthetic cover was provided on the delivery suit 24 hours a day and included an epidural service. Out of hours cover was shared with the intensive care unit. Staff told us they had not experienced concerns when requesting an anaesthetist out of hours.

The trust monitored delays in providing the epidural service. Evidence provided by the trust showed there had been nine delays across the trust (in a twelve-month period) from April 2017 to April 2018.

A birthing pool was available on Jasmine ward.

**Patient outcomes**

There was an audit programme across maternity services. Monthly measures included compliance with obstetric early warning scores, intrapartum fresh eyes, swab counts, resuscitation trolley checks, and the WHO five steps to safer surgery checklist. Data was presented at trust level, for this service.

**National Neonatal Audit Programme**

**Diana, Princess of Wales hospital:**

In the 2017 National Neonatal Audit, Diana, Princess of Wales hospital's performance in the two measures relevant to maternity services was as follows:

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 83 eligible cases identified for inclusion, 92.0% of mothers were given a complete or incomplete course of antenatal steroids.

This was better than expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit’s recommended standard of 85% for this measure.
Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 20 eligible cases identified for inclusion, 25.0% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was lower than the national aggregate of 43.5%, and put the hospital in the middle 50% of all units.

**Standardised Caesarean section rates and modes of delivery**

From October 2016 to September 2017, the total number of caesarean sections and standardised caesarean section rates for both elective and emergency cases were similar to expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective caesareans</td>
<td>12.2%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.5%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.7%</td>
<td>23.4%</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

The trust’s maternity dashboard showed the proportion of women who had an elective caesarean had decreased from 11.8% in quarter two, to 10.7% in quarter three of 2017-2018. This was slightly above the Yorkshire and Humber’s average of 10.4% for the same reporting period.

The proportion of women who had an emergency caesarean had decreased from 12.5% in quarter two, to 10.6% in quarter three of 2017-2018. The Yorkshire and Humber average for quarter three of 2017-2018, was 14.2%.

The overall rate of caesarean sections at the trust in quarter three of 2017-2018 (21.3%) was lower than the Yorkshire and Humber average (24.6%).

The maternity dashboard data for this hospital, showed from April 2017 to March 2018, the elective caesarean rate was 10.7%. This was within the trust target of 11%. The emergency caesarean rate was 10.7% and this was lower than the trust target of 15.2%. The overall rate of caesarean sections was 21.4% over the period and within the trust target of 26.2%.

In relation to other modes of delivery from October 2016 to September 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:
The trust had a higher rate of non-interventional deliveries than the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The trust maternity dashboard showed the proportion of women who had a non-interventional delivery had increased from 67.5% in quarter two, to 70.3% in quarter three of 2017-2018. This was better than the Yorkshire and Humber average of 64.8%.

The maternity dashboard for the Diana Princess of Wales Hospital showed from April 2017 to March 2018, the non-assisted delivery rate was 68.9% and the assisted delivery rate was 6.5%.

Maternity active outlier alerts

As of January 2018, the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.5. This is based on data collected from January 2015 to December 2015.

This is up to 10% higher than the average for the comparator group rate of 5.2, which indicates their performance was worse than expected.

(Source: MBRRACE UK)

The MBRRACE Perinatal Mortality Surveillance report action plan, compiled between July 2017 and November 2017 showed 16 actions. These included, increased screening, better provision of multidisciplinary training in situational awareness and human factors, clearer pathways for women who present with reduced fetal movements, and multidisciplinary management of women with diabetes.
The maternity dashboard data for this hospital showed from April 2017 to March 2018, the induction of labour rate was 29.7%; this was slightly worse than the trust target of 27.9%. From April 2017 to March 2018, the stillbirth rate total (per 1000 births) at this hospital was 2.14. This was better than the trust target threshold of 4.17.

From April 2017 to March 2018, the proportion of women who had a normal delivery experienced a third or fourth degree tear was 2.5%. Over the same period, the proportion of women who had an assisted delivery and experienced a third or fourth degree tear was 9.4%.

There were no trust targets (thresholds) for third or fourth degree tears displayed on the maternity dashboard. However, as a comparator, 6.3% of women had an assisted delivery and experienced a third or fourth degree tear within the Yorkshire and the Humber region in quarter three of 2017 to 2018.

The service had reviewed the contributory factors for the increased rates of assisted delivery third and fourth degree tears and put processes in place which they said reduced the incidence of tears.

However, maternity dashboard data for Diana Princess of Wales showed that from December 2017 to March 2018, the average proportion of women who had an assisted delivery and experienced a third or fourth degree tear was 12.1%.

From April 2017 to March 2018, 2.0% of women experienced a postpartum haemorrhage of greater than 1500mls at Diana Princess of Wales Hospital.

There were no trust targets (thresholds) for postpartum haemorrhage displayed on the maternity dashboard. However, as a comparator, 2.8% of women had experienced a postpartum haemorrhage of greater than 1500mls within the Yorkshire and the Humber region in quarter three of 2017 to 2018.

From August 2018 to April 2018, five women transferred from this hospital to Scunthorpe General Hospital. All transfers had occurred for clinical reasons.

**Competent staff**

Following our inspection in June 2017, the trust had recruited a clinical skills and patient safety midwife. The purpose of this role was to be clinically based, highly visible, coordinate the delivery of training and ensure development of the maternity workforce. The ward managers managed the allocation of mandatory training and the governance midwife said they had oversight.

The trust had an in date clinical supervision policy for registered nurses and midwives. Staff we spoke with told us supervision took place at least annually and was provided by professional midwives advocates; following the advocating for education and quality improvement (A-EQUIP) midwifery supervision model.

Medical staff undertook annual competency checks for their registration.

**Appraisal rates**

From April 2017 to January 2018 81.8% of staff within maternity at the trust had received an appraisal compared to a trust target of 95%.

Appraisal rates
This hospital had an 80.0% appraisal completion rate overall for maternity with no staff group meeting the 95% appraisal completion target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Support was provided to staff during their preceptorship period (newly qualified midwives) this included "camp care" which was a week where new staff received all IT access, and induction training. New staff were supported in theatre by the clinical skills and patient safety midwife to ensure safety was maintained.

There was a preceptorship programme to support progression for band five to band six midwives over a one to two-year period.

Community midwifery staff

From April 2017 to January 2018, 73% of qualified community midwifery staff across the trust received an appraisal compared to the target of 95%. At this location (Grimsby and Louth) 68% of staff received an appraisal in the same timeframe.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grimsby and Louth Qualified Nursing Midwifery Staff</td>
<td>25</td>
<td>17</td>
<td>95%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Appraisal rates for staff working in the hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal unit</td>
<td>95%</td>
<td>73%</td>
</tr>
<tr>
<td>Labour ward coordinators</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Midwifery Blueberry/Holly Team</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Jasmine/Honeysuckle Team</td>
<td>94%</td>
<td></td>
</tr>
</tbody>
</table>
Community midwives were trained in postnatal ‘check up’s’ and new-born and infant physical examination (NIPE). A senior community midwife told us a ‘good proportion’ of community midwives were new-born infant physical examination (NIPE) trained. However, they were unable to provide us with an exact figure. We saw an action relating to the ‘Maternity services patient safety strategy 2018-2020’ (version 4). It detailed a plan to NIPE train all community midwifery staff. This would allow women to be discharged from hospital earlier, with the proviso that new-born babies would receive a NIPE check in the community within 72 hours. The timeframe for implementation was June 2018.

Community midwives worked on-call each month and this included working at this hospital. Community midwives also rotated into the hospital for two weeks every 18 months. This helped them keep up to date with their competencies and skills.

During the inspection, senior community staff told us that all community midwives at the trust had undertaken additional ‘baby lifeline’ training focussed on childbirth emergencies in the community. An external provider facilitated the training in Manchester. There were two cohorts of community midwives, and training had taken place in December 2017 and March 2018. The training was multidisciplinary and completed alongside ambulance crews.

A specialist bereavement midwife was in post, and worked across all sites. There was also a consultant-led ‘rainbow clinic’. The ‘rainbow clinic’ was a specialist service for women and their families in a subsequent pregnancy following loss. A new programme of bereavement training had been implemented, with dates offered for May and October 2018. Training was available for midwives (full-day) and healthcare assistants in midwifery services (half-day). The training schedule included monitoring, diagnosis of miscarriage, treatment of miscarriage, ectopic pregnancy, funeral arrangements following pregnancy loss, and emotional care.

Maternity services staff had been invited to attend a baby loss and bereavement care conference at St Andrew’s Hospice, in August 2018.

**Multidisciplinary working**

There was a formalised structure of meetings in place to enable multidisciplinary team working. These included monthly maternity governance meetings and perinatal mortality and morbidity meetings.

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

Annual emergency skills and drills training and ALERT (Acute Life-threatening Events Recognition and Treatment) training took place alongside medical (obstetric) staff. Community midwives had baby lifeline’ training focussed on childbirth emergencies in the community, which involved training alongside ambulance crews.

**Seven-day services**

Maternity services had access to diagnostics and imaging services out of hours.
Anaesthetic cover was provided on the delivery suite 24 hours a day, and included an epidural service. However, out of hours cover was shared with the intensive care unit. We identified four occasions in a 12-month period, (between May 2017 and April 2018), where staff reported a delay of more than 30 minutes, in the provision of an epidural service.

One of the doctors told us they had no experience of opening a second theatre at night. However, during the day there was no problem opening a second theatre when needed.

There had been no incidents reported relating to the provision of theatre services.

(There was an in date standard operating procedure for the use of a second theatre and there was a theatre scrub competency training package for the midwives (band 5/6) to assist in theatre.)

On-call community midwives were available twenty-four hours a day, seven days a week.

A serious incident had occurred in the community in the 12 months prior to our inspection.

Learning from the incident (report completed April 2018,) included a request by the interim Head of Midwifery to implement a more robust on-call system for community midwives, including a second on-call system, for all home births. Discussion with one of the community managers identified a second on call member of staff is used.

**Health promotion**

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in smoking cessation, substance abuse, and infant feeding.

There was a consultant midwife with a lead for teenage pregnancies and public health. The maternity dashboard data showed the proportion of women smoking at time of booking across the trust was 20.8% in quarter three of 2017-2018. This was higher than the trust's target rate of 11% and higher than the Yorkshire and Humber average for the period (18.4%).

The proportion of women smoking at time of delivery across the trust was 21.2% in quarter three of 2017-2018. This was higher than the trust’s target rate of 11% and higher than the Yorkshire and Humber average for the period (13.4%).

Maternity dashboard figures for Diana Princess of Wales Hospital showed that from April 2017 to March 2018, the proportion of women smoking at time of booking was 21.9% and the proportion of women smoking at time of delivery was 19.9%.

Senior community midwifery staff told us smoking cessation clinics were available in the locality. However, smoking rates were high, as the areas covered were socio-economically deprived. As part of their MBRRACE Perinatal Mortality Surveillance Report action plan, the trust was investigating service provision for smoking cessation services, with a view to expanding provision. The report was submitted to Directorate Governance Group in April 2018.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust did not provide mental capacity act and deprivation of liberty safeguards training data.

(Source: Trust Provider Information Request P14/P49)
There was a trust-wide Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) policy; due for renewal April 2018. There was a MCA/DoLS lead in place at the trust, who told CQC staff that a new policy had been written and was awaiting final ratification.

There was also a trust level named nurse for the Mental Capacity Act (MCA) and /Deprivation of Liberty Safeguards (DoLS). The area of risk was identified in 2017, and the post established. The Safeguarding Lead for the trust told us the MCA and DoLS training was delivered with a focus on consent to treatment.

During our visit, a senior member of staff told us that MCA and DoLS training sessions were planned for community midwives, but that dates were not yet available.

The trust had a policy for consent to examination or treatment, with a review date of June 2017. Women told us they were given sufficient information to enable them to make an informed choice about the delivery of their baby.

We saw evidence in patient’s records of consent forms completed for women undergoing caesarean sections and instrumental deliveries. Consent forms detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.

Midwives and nursing staff were able to articulate how they would ensure consent was obtained either verbally or written prior to a procedure.

Staff we spoke with at the midwifery-led unit and in the community clearly articulated the use of Gillick competency for consent of patients under the age of 16 years.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

**Friends and family test performance (antenatal), Northern Lincolnshire and Goole NHS Foundation Trust**

From January 2017 to January 2018 the trust’s maternity friends and family test (antenatal) performance (% recommended) was in line with the England average for all months in the period aside from June and July 2017 where performance fell below the England average. The trust reported 100% recommend for three months during the period (March, May and August 2017).

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns and the trust had less than six responses in December 2017 and January 2018 which shows on the graph as 0% recommend.
Friends and family test performance (birth), Northern Lincolnshire and Goole NHS Foundation Trust

From January 2017 to January 2018 the trust’s maternity friends and family test (birth) performance (% recommended) was better than or in line with the England average, reporting 100% recommend for six months during the period (February, March, April, May, June and December 2017).

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

Friends and family test performance (postnatal ward), Northern Lincolnshire and Goole NHS Foundation Trust

From January 2017 to January 2018 the trust’s maternity friends and family test (postnatal ward) performance (% recommended) was better than or in line with the England average, reporting 100% recommend for seven months during the period (February, June, July, August, September, October 2017 and January 2018).

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

Friends and family test performance (postnatal community), Northern Lincolnshire and Goole NHS Foundation Trust

From January 2017 to January 2018 the trust’s maternity friends and family test (postnatal community) performance (% recommended) was generally worse than the England average. The
trust reported less than six responses in four of the months in the period (February, March, April 2017 and January 2018) which show on the graph as 0% recommend.

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017

The trust performed about the same as other trusts for all 19 questions in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>7.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.7</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>6.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>5.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>7.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td>Information or explanations you needed?</td>
<td>9.0</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>kindness and understanding?</td>
<td>8.2</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with you as much as you wanted?</td>
<td>8.4</td>
<td>About the same</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

A review of maternity services at the site undertaken by representatives from the trust, local Clinical Care Commissioning groups (CCG), and Healthwatch was carried out 28 September 2017. Findings stated all women spoken with had a lot of praise for the caring nature of staff in the wards, delivery suite and theatres. Staff were said to go “above and beyond” and their approach was consistently caring.

**Emotional support**

There were guidelines and care pathways in place at the trust to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death.

There was a consultant-led ‘rainbow clinic’. The ‘rainbow clinic’ was a specialist service for women and their families in a subsequent pregnancy following loss; and women were able to self-refer. A specialist bereavement midwife was in post, who worked across sites.

There was an information booklet outlining options for funeral arrangements, which offered the services of the hospital chaplaincy and the support of local funeral directors, if needed. The booklet contained information about an annual baby memorial service, and a baby memorial book; held in the hospital chapel.

We saw that the trust is working with Sands (the stillbirth and neonatal death charity) to implement and test a new National Bereavement Care Pathway (NBCP) for pregnancy and baby loss. The trust implemented the pathway in April 2018, and will be working with Sands to understand the impact of the pathway and its effectiveness in improving bereavement care for parents. Five experiences of pregnancy or baby loss are included in the pathway including miscarriage, termination of pregnancy for foetal anomaly, stillbirth, neonatal death and the sudden unexpected death of an infant up to 12 months.

‘Butterfly stickers’ were used in antenatal notes to indicate when a woman had previously experienced pregnancy loss and baby bereavement. Butterfly door signs were used in the hospital to indicate a current loss.

Maternity services had introduced ‘cherished care packs’, to be given to parents following a still birth or neonatal death. There was a range of keep sake materials available for women to choose from, to suit different types of loss and different baby gestations.

Information leaflets available about baby loss and bereavement were available, including those from the Mariposa Trust, ‘4Louis’, and the ‘Blue Butterfly Support Group’. These included contact details for national charities and local support groups.

Staff said perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period.
Understanding and involvement of patients and those close to them

In the 2017, CQC maternity survey, for being involved enough in decisions about their care during labour and birth, women scored the trust 8.9 out of 10 (which was about the same as other trusts, and an improvement on their 2015 score of 8.4).

An external provider undertook a survey of women who had recently used maternity services at the trust in September 2017. An action plan had been developed to address women’s concerns and recommendations. For each action, there was an action lead, timescale for completion (all set for August 2018) and expected evidence of completion (anticipated changes to practice and delivery).

In the antenatal period, the service planned to implement greater choice of where to have check-ups, greater awareness of women’s medical history, better continuity of care, and greater focus on emotional and mental well-being. The plan recognised that during birth, women needed to be able to move more freely, have concerns taken seriously, and be treated with dignity and respect. Improvements in postnatal care included considering women’s preferences about the length of hospital stay (if applicable), attending to women more quickly, listening to and respecting women’s decisions, providing or signposting to enhanced emotional care, and providing more information about postnatal check-ups.

There was a Maternity Voices Partnership in place at the trust. The partnership had a remit to enable hospital trust and other service providers to listen to and take account of the views and experiences of maternity service users. Parents who had delivered a child at the trust in the last three years were invited to join and share their experiences of care. The group was comprised of local parents, commissioners, hospital, community and council staff, and chaired by a local mother. The group met every two months in either Scunthorpe General Hospital or this hospital and there was a social media page and online forum. Experiences of care could also be submitted by email.

We saw compliments submitted between November 2017 and March 2018, from women who had birthed at this hospital. Comments detailed the “amazing” and “wonderful” care provided by the “lovely” staff. Comments indicated that staff had worked to meet the individual needs of patients. These included, clear communication, being attentive, and involving women in decision-making and giving them a good sense of control.

A review of maternity services at the site undertaken by representatives from the trust, local clinical care commissioning groups, and health watch was carried out 28 September 2017. Findings stated staff were attentive and responsive if women had any immediate needs or worries.

Is the service responsive?

Service delivery to meet the needs of local people

Women had the option to either deliver at home, in the midwifery led unit at Goole and District Hospital, this hospital, or Scunthorpe General Hospital.

Community midwives carried out routine antenatal care. Hospital antenatal clinics were available for higher risk women. Midwives could refer expectant mums to the hospital antenatal clinic if they developed any problems.

Maternity services worked with the local commissioners of services, the local authority, other providers, GP’s and patients to coordinate care pathways. Clinics were held within the antenatal clinic to support women, such as smoking cessation clinics and diabetic clinics.
The service offered a labour, delivery, recovery and postnatal (LDRP) model of care. This enabled women to stay in the same room throughout their stay. Partners were encouraged to stay overnight from delivery to support their partners and help take care of the baby.

**Bed Occupancy**

From Q2 2016/17 to Q3 2017/18 the bed occupancy levels for maternity were lower than the England average in all periods, with the trust having 44.1% occupancy in Q3 2017/18 compared to the England average of 58.9%

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Data provided by the trust showed from April 2017 to March 2018, 48% of maternity beds were occupied at midnight (mothers only) across the trust.

Over the same period, 47% of maternity beds were occupied at midnight (mothers only) at Diana Princes of Wales Hospital. Of these, 49% of beds were occupied at midnight on Holly ward, 48% on Jasmine ward, 48% on Blueberry ward, and 42% on Honeysuckle ward.

From April 2017 to March 2018, data showed 55% of maternity beds were occupied at midday (mothers only) at Diana Princes of Wales Hospital. Of these, 58% of beds were occupied at midday on Holly ward, 56% on Jasmine ward, 56% on Blueberry ward, and 49% on Honeysuckle ward.

**Meeting people’s individual needs**
Women could book their initial antenatal appointment directly, by telephone or online and did not require referral.

Women were offered the choice to deliver at home, in a midwifery-led birthing suite, or in hospital. The service offered educational childbirth preparation classes run by midwives. Topics included, comfort, back pain and exercise in late pregnancy, signs of labour and when to come into hospital, natural coping strategies, stages of labour including pain relief options, assisting your partner in labour, variations of normal delivery including caesarean section, introduction to breastfeeding and life after birth.

Midwives were available for support and guidance with special interests as part of their role. These included midwives who specialised in safeguarding, teenage pregnancy, smoking cessation, substance abuse, bereavement, and infant feeding.

A face-to-face and telephone translation service was available, provided by ‘Big Word Translation’ services and British Sign Language signers.

The trust had also applied ‘Browse Aloud’ to their external web pages, to enable audio capabilities for those with visual impairments. ‘Browse Aloud’ allowed users to listen to an audio reading of web content in different languages.

There was a chapel and a prayer room at this hospital with multi-faith provision. The chaplaincy team at the trust provided an out of hours on-call service for part of the week.

There was a policy and procedure for ‘Spiritual Care Standards’ (DCP280) in place at the trust, which outlined the importance of respecting the religion and belief of all, regardless of creed.

Access and flow

The trust reported no maternity unit closures for the 12 months prior to inspection.

From April 2017 to March 2018, the bed occupancy levels for maternity were lower than the England average.

The maternity dashboard data showed from February 2017 to January 2018, (inclusive) 89.5% of initial antenatal bookings across the trust were undertaken before 13 weeks. This was marginally below the trust target of 90% and below the Yorkshire and Humber average for the period (91.7%).

For the same period, bookings within the 13-week threshold minus agreed exclusion targets (such as mothers presenting later in pregnancy) was 97.4%.

There were processes in place to follow up women who did not attend appointments, either in the community or hospital setting. This was to ensure the well-being of the mother and their child.

Learning from complaints and concerns

Summary of complaints

From February 2017 to February 2018, there were 19 complaints about maternity services (4% of total complaints received by the trust). These included nine complaints about maternity services at Diana, Princess of Wales Hospital and 10 at Scunthorpe General Hospital.

The trust took an average of 47 working days to investigate and close complaints at the hospital. This is not in line with the trust targets for closing complaints within 30 working days, or the further target of 45 working days.

A breakdown of the subject of complaints at this location is shown below:
• Patient care – seven complaints
• Values and behaviours (staff) – one complaint
• Integrated care (including delayed discharge due to absence of care package) – one complaint.

(Source: Trust Provider Information Request P55)

Of these, three were currently under investigation, one had been withdrawn, and five complaints were not upheld.

There was a complaints policy and procedure in place, which staff we spoke with were aware of. We saw patient advice and liaison service (PALS) information leaflets on display in the areas we visited. We also saw trust information leaflets on display in the waiting area about how to make a comment, compliment or complaint.

Across the trust, learning from incidents was discussed at divisional governance and patient safety meetings, and information cascaded to staff at team meetings, safety huddles, and at handovers.

We reviewed monthly Obstetrics & Gynaecology Clinical Governance meeting minutes for January, February and March 2018. These detailed PALS and complaints received by hospital site, and the number of open complaints. Data was inclusive of obstetrics and gynaecological services.

During our visit, we saw a ‘lesson of the week’ circular (dated 04 May 2018,) that detailed a thematic summary of the ‘top five PALS/complaints’ across maternity services at the trust. These included communication, clinical treatment/care, staff values and behaviours, misfiling, and appointments including delays and cancellations.

Is the service well-led?

Leadership

Maternity and gynaecology services formed part of the women’s and children’s group. Staff across the Women and Children’s Group completed a survey in 2017, facilitated by an independent provider, and a report was published 31 August 2017. Poor scores for organisational culture were noted. The report highlighted that scores reflected critical problems requiring cultural and structural transformation, some changes in leadership, and leadership development and coaching.

At the time of inspection an associated chief operating officer (ACOO), a group clinical lead (GCL) for obstetrics and gynaecology and an interim head of midwifery (IHOM) led the service. Each hospital site had an operational matron and there was a lead consultant for labour ward.

A non-executive director represented the service at board level. Since our previous inspection in 2016 staff reported the service had received a greater focus and scrutiny from the trust board.

The interim head of midwifery had been in post for eight months prior to our inspection. All staff spoke positively of the changes and progress the service had made during this period.

The group clinical director had recently come into post prior to our inspection. Staff reported they were confident in this person to lead the clinical team.
There was a coordinator in charge of each shift; this person had oversight of the whole unit. We found they were accessible to all staff; offering support and guidance when required.

We saw the contact details of the whole consultant body on display in clinical areas. Staff reported they were encouraged to call consultants if they were concerned.

The service was receiving support from NHSI in the form of an external partnership with a consultant. The aim was to support the leadership team to drive improvement. At the time of inspection support had been provided of six days and was in the early stages.

**Vision and strategy**

The service had a three to five-year strategy which included strategic objectives and action plan to implement the strategy.

The strategy supported the implementation of better births review of maternity services. It also reviewed clinical and financial pressures and was available in the public domain.

The Women and Children’s Division Strategic Objectives 2017-2020, set out maternity services mission “…to provide safe, effective and leading-edge care to the population we cover through nurturing high performing teams that prioritise patient care”.

The vision was for “…every woman and child in our locality is healthy and happy”. Five main strategic goals were stated. These included, encouraging the use of innovative ideas, evidence based techniques and treatments; by developing midwife/specialist nurse led care, and improving diagnosis and management of ‘small for gestational age’ fetus. In addition, to have the right levels of staff, appropriately trained and delivering excellent care in a positive, compassionate environment. This meant ensuring ‘Birth-rate plus’ establishment for midwifery and safe staff-to-patient ratios were maintained, and ensuring appropriate staffing levels.

**Culture**

We observed good team working, with midwives working collaboratively and with respect for each other’s roles. All staff spoke positively and were proud of the progress the service had made since our 2016 inspection.

Evidence provided by the trust showed they had undertaken a staff survey, published in August 2017, to identify the morale of staff. Themes included a lack of positive feedback, and staff reported being valued by patients and their immediate manager but not by the trust as a whole. A follow up survey undertaken in January 2018, showed an improved picture, where staff felt listened to and valued by the Interim Head of Midwifery (IHOM).

Staff told us they were encouraged to be open and honest. This had improved since the new clinical lead had come into post.

Staff told us they felt the senior leadership team did not all have a clinical focus and this had caused a disconnect between some of the leaders and the clinical team. Staff reported some leaders had an autocratic leadership style which did not focus on patients but the bottom line.

We observed a well-established consultant body who supported each other. However, this included covering the rota for a colleague who, at the time of inspection was not undertaking clinical work on Labour ward. Staff told us this further reduced the service’s ability to provide complete 60hr labour ward consultant cover as recommended.

**Governance**
Following our previous unannounced inspection in 2017, the service had employed a full-time
governance midwife who worked across both the Diana, Princess of Wales site and Scunthorpe
General Hospital Site. Support was provided by the trust wide governance team with a
governance facilitator and additional secretarial support.

There was also a lead obstetrician for governance. This was a recent appointment prior to our
inspection.

The governance midwife led on most of the incident root cause analysis (RCA) reports and they
were also allocated to individuals by the triumvirate.

The service held monthly governance meetings. We reviewed minutes of meetings between
January 2018 and March 2018. The current risks of the service were discussed and this included
the mandatory training compliance rates.

Staff told us the service held daily caesarean section audits. However, this appeared to be more of
a discussion about which case needed to be escalated to the patient safety group for review.

Management of risk, issues and performance

There was a women’s and children’s group risk management strategy, (version 5.3, expiry date
February 2019). It was reviewed and approved by the Children’s Services Governance, Obstetrics
& Gynaecology Governance, and the trust Governance & Assurance Committees in September
2015 and April 2016. The strategy outlined the processes for managing and escalating risks,
individual responsibilities and their strategy for achieving this objective.

Key policy areas included the identification, assessment, control and review of risk, the risk
register, process for escalation and assurance, reporting and management of incidents, serious
incidents, never events, maternal deaths, and learning of lessons.

We reviewed the risk register. There were 13 risks associated with obstetrics and community
midwifery on the directorate register, dated February 2018. There was evidence the register was
reviewed and update. We also saw the risk register was discussed in the monthly governance
meeting minutes. The information included the action taken to mitigate the risks and timescales.

We also found an overview of serious incidents, incidents and complaints presented in monthly
Obstetrics and Gynaecology Clinical Governance meeting minutes for January, February and
March 2018. Items included a summary of serious incidents that had occurred in the preceding
month, incidents by hospital site for the preceding month, incidents by severity, and thematic
summary of the most commonly occurring incidents. Incident data was inclusive of Obstetrics and
Gynaecology services. Meeting minutes from both January and March 2018 detailed the root
cause analyses from previous (completed) investigations had been fed back to the group.

The ‘Maternity services Patient safety strategy 2018- 2020’ (version 4) presented a plan to
maximize safety and reduce harm experienced by people receiving care in maternity services.
This included, ensuring staff were aware of their responsibilities in relation to safeguarding
patients, and take appropriate action to maintain the safety of vulnerable service users. The
strategy identified areas within maternity services that required improvement. These included safe
pathways and practices of care, patient feedback, safe levels of staffing, competent and skilled
staff, and patient centred care. The strategy contained an action section that detailed named leads
and responsibilities to achieve the outcomes. At the time received, eight of the actions had an
agreed timescale for implementation recorded. These predominantly concerned actions centred
around ensuring a fair patient focussed culture, good team working and good morale, and the safe
use of equipment (including IT services).
The maternity dashboard was location specific and discussed at the monthly governance meetings. The service submitted data to the Yorkshire and Humber regional maternity dashboard. This meant the service could compare its performance against other local trusts and the Yorkshire and Humber average.

**Information management**

Staff reported Information technology had improved. This included the implementation of the electronic Modified Early Warning Score (MEWS) and WebV; a visual, electronic patient record system.

There was a centrally held document control register. The register listed all trust policies and clinical guidelines; alongside version control, review date, and the stages of review of information (where applicable). A named individual at the trust had oversight of the register. The governance midwife informed us that a maternity specific document register was emailed to her each month for oversight. Appropriate actions were in place for maternity specific documents that had expired or were approaching their review date.

The minutes of the Obstetrics and Gynaecology Governance Group showed monitoring of controlled documents within the services. Document Control Percentages reported in March 2018 showed:

- Clinical documentation – 128 documents, 4 overdue = 97% compliant
- Guidelines – 127 documents, 1 overdue = 99% compliant
- Patient leaflets – 76 documents, 4 overdue = 95% compliant

There was a ‘Maternity Project Plan’ in place. At the time of viewing this was dated to 18 May 2018. A key milestone was electronic recording of the Obstetrics Early Warning Score (OEWS) for all women expect those receiving high dependency care. This was marked as fully completed in August 2017.

**Engagement**

We noted low Friends and Family Test (FFT) responses across the trust maternity services. No data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns. The trust had less than six responses in December 2017 and January 2018 for antenatal care; this resulted in 0% recommended. The trust also reported less than six responses in four months (February, March, April 2017 and January 2018) for postnatal community performance; this too resulted in 0% recommended.

An external provider carried out a survey of women who used maternity services at the trust in September 2017. An action plan was developed to address women’s concerns and recommendations. For each action, there was an action lead, timescale for completion (all set for August 2018) and expected evidence of completion (anticipated changes to practice and delivery).

There was a Maternity Voices Partnership in place at the trust. The partnership had a remit to enable hospital trusts and other service providers to listen to and take account of the views and experiences of maternity service users. Parents who had had a child at the trust in the last three years were invited to join and share their experiences of care. The group was comprised of local parents, commissioners, hospital, community and council staff, and chaired by a local mother. The group met every two months in the Diana Price of Wales Hospital, or Scunthorpe General Hospital, and there was a social media page and online forum. Experiences of care could also be submitted by email.

**Learning, continuous improvement and innovation**
A review of maternity services was undertaken by representatives from the trust, local Clinical Care Commissioning Groups (CCG’s), and Healthwatch on 28 September 2017. The trust also invited the Royal College of Gynaecologists (RCOG) to review and assess maternity services; this took place shortly after our visit in May 2018. The terms of reference showed 10 keys points for consideration, and included a review and assessment of the following areas:

- Current model for the delivery, including the progress and pace of the maternity services improvement plan.
- Prevalence and effectiveness of a patient safety culture.
- Serious incident investigation processes, and evidence and implementation of learning.
- Current midwife and obstetric workforce and staffing.
- Culture within maternity services, including inter-professional relationships and staff engagement.
- Structure and schedule of meetings and training activities in place.
- Areas of leadership and governance that would benefit from further targeted development.
- Level of patient engagement and involvement within the maternity services.

In early 2018, women who gave birth at the Diana Price of Wales Hospital, Scunthorpe General Hospital or Goole District Hospital were asked to give a special thank you to their midwife by nominating them for an award. Staff in maternity services hosted a tea party in celebration of the midwives. The midwives shared their experiences and the reasons they loved working in the profession. This took place in May 2018. On the day, the winners of the ‘NLaG Outstanding Midwife 2018 award’ were also announced.

In April 2018, the trust implemented a National Bereavement Care Pathway (NBCP) for pregnancy and baby loss. This was developed in conjunction with Sands (the stillbirth and neonatal death charity).
Facts and data about this service

The trust has 43 critical care beds. A breakdown of these beds by type is shown below.

**Breakdown of critical care beds by type, Northern Lincolnshire and Goole NHS Foundation Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal, 51.2%</td>
<td>Adult, 68.4%</td>
</tr>
<tr>
<td>Adult, 48.8%</td>
<td>Neonatal, 23.8%</td>
</tr>
<tr>
<td></td>
<td>Paediatric, 7.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England- Critical Care beds 01/12/2017 – 31/12/2017)

The trust has a critical care service without walls; the service includes outreach services, a sepsis nurse, vascular access and a deteriorating nurse consultant.

Diana, Princess of Wales Hospital has a six-bedded level two and three intensive care facility. This provides level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care. The unit has a bay containing four beds and two single rooms. The beds flexed between level two and level three as required. The unit could care for a maximum of six level three patients.

This site also has a separate seven bedded high dependency unit (HDU), which provides level two care.

As of January 2018, there were 92.9 whole time equivalent (wte) nursing staff and 32.7 other clinical wte staff.

(Source: Trust Routine Provider Request)

A critical care outreach team provides a supportive role to the wards caring for deteriorating patients and support to patients discharged from critical care during the day. The hospital at night team provides cover at night. A recent change in hours to both team meant each worked 12-hour shifts enabling a twenty-four seven service.

The critical care service is part of the East Yorkshire and Humberside Critical Care Network. Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2017 and 31 December 2017 on the intensive care unit at this site, there were 290 admissions with an average age of 61 years. Sixty six percent of admissions were non-surgical, 8% were planned surgical admissions and 26% were emergency surgical admissions. The average length of stay on the unit was two days.
The units did not accept paediatric admissions. The anaesthetist or consultants would attend in an emergency and stabilise the patient until a bed was available on the neonatal ICU or the dedicated intensive care transport service for children arrived. The unit had an inter hospital transfer policy which was in line with the critical care network and national guidelines.

### Is the service safe?

#### Mandatory training

##### Mandatory training completion rates

**Diana, Princess of Wales Hospital**

The trust set a target of 85% for completion of mandatory training at the previous inspection it had been 95%.

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>57</td>
<td>61</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>55</td>
<td>61</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>55</td>
<td>61</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>54</td>
<td>61</td>
<td>89%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>54</td>
<td>61</td>
<td>89%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>52</td>
<td>61</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>50</td>
<td>61</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>48</td>
<td>61</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>46</td>
<td>61</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>41</td>
<td>61</td>
<td>67%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff at Diana, Princess of Wales Hospital had an overall training completion rate of 84%, just short of the trust target of 85%. The trust target was reached and exceeded for six of the ten mandatory training modules. The training module, PREVENT Level 1, had the lowest completion rate of 67%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We were provided with different figures with regards to mandatory training compliance. Information provided on site on the intensive care unit (ICU) showed that overall mandatory training compliance for April 2018 was 55%. We requested more recent training information from the trust. The information provided showed mandatory training compliance for ITU staff was 86% as of April 2018. Training compliance for nursing staff on HDU up to April 2018 was 73%, which was below the trust target of 85%.
We requested mandatory training data for medical staff within critical care and compliance was 75%.

Training on sepsis was provided for all staff via an e-learning module.

**Safeguarding**

**Safeguarding training completion rates**

**Diana, Princess of Wales Hospital**

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for nursing/midwifery staff shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>47</td>
<td>61</td>
<td>77%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>47</td>
<td>61</td>
<td>77%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>46</td>
<td>61</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff at Diana, Princess of Wales Hospital did meet the trust target of 85% for any of the three safeguarding training modules, with an overall completion rate of 77%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We requested training data for medical staff and compliance rates were 84% for adults safeguarding training and 87% for level one and two children’s safeguarding. Compliance for children’s level three safeguarding was 100%.

Trust protocols and guidance on safeguarding were easily accessible and there was a safeguarding team who could be contacted if further advice was needed.

Staff we spoke with could describe what may be seen as a safeguarding concern and how they would escalate this. Senior nurses were confident about staffs understanding of safeguarding.

**Cleanliness, infection control and hygiene**

Seventy nine percent of nursing staff had completed infection control training. This did not meet the trust target of 85%.

Intensive Care National Audit and Research Centre (ICNARC) data showed there had been five unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2017. The year to date percentage of unit acquired infections in blood per 1000 patient bed days was 3.6 which was in line with national averages (1.2 – 8.3). However, when compared to similar units; rates were higher (3.6 against 2.0) The graph below shows that in 2017-2018 there was a notable rise. We discussed this with the senior management team who said each case had been investigated and no themes had been found.
Information from April 2017 to December 2017 showed there had been no unit acquired cases of methicillin resistant staphylococcus aureus (MRSA) or *clostridium difficile*.

Hand hygiene points were at the entrance to the ICU and HDU and alcohol gel was available at every bed space. Infection control information was displayed to staff and visitors on the unit. Monthly frontline ownership audits were completed. We were provided with the divisional dashboard, this showed compliance against 10 standards including waste disposal and sharps safety. Data from April 2017 to April 2018 showed overall seven areas were rated as green and three rated as amber. However, we were concerned that within the bay ICU on there were no clinical waste bins, staff reported this had been the case for some time. Open clinical waste bags were hanging from the tables next to each bed. We raised this with senior nursing staff at the time of inspection. We also found two sharps disposal bins which had been overfilled. This was raised with the staff on the unit who attended to this.

On the HDU we observed an open waste bag and a bag of infected linen on the floor on the main corridor. We also observed a full sealed bag containing clinical waste in the sink in the dirty utility room. These were all removed later in the morning by domestic staff.

Domestic staff informed us they worked across HDU and the ward and were unable to clean the floors in the bed areas each day. This was evident and dust and bits of waste such as caps off infusion sets were seen on the floor in the bays.

We saw information displayed on the prevention of legionella and how to manage a blood spills. High impact interventions were in place for ventilator associated pneumonia (VAP). These looked at best practice and compliance with evidence based practice for specific procedures. Data from August 2017 to May 2018 showed 100% compliance in all areas with no cases of VAP.

With the exception of the clinical waste bags at bed spaces, areas within the ICU were visibly clean and tidy. Since the last inspection two ‘pods’ had been installed which provided facilities for respiratory isolation.

We observed staff interactions with patients, including those requiring isolation, and all were compliant with key trust infection control policies. Hand hygiene and the use of personal protective equipment (PPE) was undertaken by all staff we observed. Appropriate signage was also seen for patients requiring isolation.
Environment and equipment

The ICU was still in its temporary location as was the case at the last inspection. This remained on the departmental risk register with a low risk score and evidence of a review in December 2017. The environment had been improved with the addition of the isolation pods and some additional storage.

Access to the ICU was via intercom with a security camera and there was central monitoring in place. The unit had windows allowing natural light in, however the space limitations meant it was not fully compliant with health building notice (HBN) 04-02. There was direct access to theatres via a corridor from the unit.

Access to the HDU was via an intercom and there was direct access to the medical assessment unit. Staff reported that storage was limited on the unit. Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance. To maintain patients’ privacy the bed spaces were separated by curtains.

There was adequate equipment in the unit to meet the needs of patients. The replacement of equipment was done as part of the trust wide capital replacement programme and the ICU had new ventilators purchased the previous year.

Specialist equipment was available for patients with a high body mass index (BMI) when required. We checked 18 pieces of equipment for evidence of in date electrical testing. We found these to be in place and in date on all the equipment checked.

There was a resuscitation trolley centrally located on the HDU and ICU. We saw evidence of daily checks being completed. Contents were checked and found to be sealed and in date.

Assessing and responding to patient risk

The critical care outreach team (CCOT) provided cover seven days a week from 8am to 8pm at Diana, Princess of Wales Hospital. Overnight cover was provided by the hospital out of hours team.

The trust used the national early warning score system (NEWS) as a tool for identifying deteriorating patients. The wards had an electronic system for recording patient observations. This allowed the CCOT to remotely view any patients with elevated NEWS scores. There was a clear escalation policy in place for when patients had an elevated NEWS score.

The CCOT played a vital role in supporting staff on the wards when patients become unwell. They had a number of other roles including, attending cardiac arrest calls and providing support for patients with tracheostomies or requiring non-invasive ventilation. They also reviewed patients who were discharged from ICU to ward areas.

There nurse consultant for the deteriorating patient managed the CCOT and some of the specialist nurses. The teams had a deteriorating patient dashboard. This enabled data to be analysed and if there were any wards or areas of concern they could be addressed by either further training or support for staff.

Sepsis screening tools and pathways were in use and mandatory training on sepsis had been introduced. Sepsis formed part of the ALERT course training for nursing staff. This had changed in February 2018 and incorporated a formal competency assessment with staff having to achieve a certain level to pass the course. This was to ensure through understanding and learning was achieved by staff.
Local safety standards for invasive procedures (LocSSIPs) had been revised and a central venous access device pathway had been developed. This brought together a number of policies and guidelines which had previously been separate documents. The standardisation of central lines had taken place so only one type was used. A database was also held of all central lines inserted to provide oversight and monitoring.

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

Staff we spoke with knew how to access the mental health support. There was access to specialist nurses, psychiatric and crisis teams.

**Nurse staffing**

Northern Lincolnshire and Goole NHS Foundation Trust reported their staffing numbers below as of January 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post January 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>108.3</td>
<td>92.9</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital had a staffing fill rate of 85.8%; this means that the service had to function with 15.4 less wte staff members than it had planned for.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 12%, for nursing and midwifery staff in critical care, which is higher than the trust overall target rate of 6.28%.

- Diana, Princes of Wales: 12.9%

(Source: Routine Provider Information Request (RPIR) - Vacancies)

**Turnover rates**

From February 2017 to January 2018, Northern Lincolnshire and Goole NHS Foundation Trust reported an overall turnover rate of 8.9%; this was an average for nursing and midwifery staff in critical care from the two hospital sites. The average percentage was lower than the overall trust target turnover of 9.4%. However, for this site it was higher.

- Diana, Princess of Wales Hospital: 11.1%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From January to December 2017, Northern Lincolnshire and Goole NHS Foundation Trust reported a sickness rate of 5.0%, for nursing and midwifery staff in critical care; this was higher than the trust target of 4.1%.

- Diana, Princess of Wales: 4.9%
Bank and agency staff usage

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Agency shifts</th>
<th>Bank shifts</th>
<th>Unfilled shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0.0%</td>
<td>96 (44%)</td>
<td>48 (22%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>182 (13%)</td>
<td>372 (27%)</td>
<td>225 (17%)</td>
</tr>
</tbody>
</table>

For both qualified nurses and nursing assistant staff, Diana, Princess of Wales Hospital had an agency staff usage rate of 13.5%, a bank staff usage rate of 27.5% and 16.6% of shifts were left unfilled.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Nurse staffing was based on guidance and standards from D16 NHS standard contract for adult critical care and Guidelines for the Provision of Intensive Care Services 2015 (GPICS). Nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients’ ratio for level two patients. Staff reported this could be impacted by staff being moved to support other areas in the hospital. Locally collected data from ICU showed between January 2018 and April 2018 staff had been moved off the unit on 70 occasions. Staff told us when this occurred it may result in the supernumerary co-ordinator no longer being available. We reviewed incident data from November 2017 to April 2018 and only found one incident of staffing levels not being appropriate for the dependency of the patients.

Planned and actual staffing numbers were displayed and were achieved during our inspection. Planned staffing levels for the ICU was seven nurses and one health care support worker on duty during the day and seven nurses at night. The planned staffing levels allowed for a supernumerary co-ordinator to be on duty at all times. This was an improvement from the last inspection and in line with GPICS recommendations.

Planned staffing levels of HDU were four nurses on duty during the day and night with a health care support worker on the early shift and the night shift.

Information on the trusts website showed fill rates for the intensive care unit during the day from October 2017 to February 2018 were 99%-107% dropping to 93% in March 2018. For the same time period, fill rates for night shifts were between 95% and 102%.

Vacancy rates and sickness did make staffing a challenge; however, no concerns were fed back from nursing staff with regarding to staffing levels. Gaps in staffing were covered by agency staff or bank staff. Many of these shifts were filled by the unit’s own staff working additional shifts. From reviewing rotas, we were assured that staffing was in line with GPICS. The unit did not utilise greater than 20% of registered nurse from bank or agency on any one shift which weren’t their own staff.

The CCOT consisted of five staff with one nurse on duty each day. Due to the size of the team, there could be gaps in service if there was annual leave or any sickness. The team aimed to provide a seven-day service.

Medical staffing

The trust has reported their staffing numbers below as at January 2018.
<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan 18)</th>
<th>Actual WTE (Jan 18)</th>
<th>Planned WTE (Jan 17)</th>
<th>Actual WTE in month (Jan 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>32.6</td>
<td>39.4</td>
<td>34.5</td>
<td>35.7</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital had a staffing fill rate of 120.9%, indicating that the service had 6.8 more WTE staff members in post than was planned as at January 2018.

Scunthorpe General Hospital has a staffing fill rate of 107.4%, indicating that the service had 2.4 more WTE staff members in post than was planned for.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

As from February 2017 to January 2018, the trust reported an overall vacancy rate of 3.1%, for medical and dental staff in critical care;

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE as at January 2018)</th>
<th>Total number of staff establishment (WTE as at January 2018)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>-6.8</td>
<td>32.6</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Both sites had vacancy rates lower than the trust target vacancy rate of 6.3%.

Please note, while the figures for January 2018 show an over establishment at both sites, the annual rate is calculated over the 12-month reporting period.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Bank and locum staff usage

From February 2017 to January 2018 the trusts reported a bank and locum usage rate of 99% in critical care. The trust provided figures for both doctors in training and middle grade doctors, for Diana, Princess of Wales Hospital and Scunthorpe Hospital. Data provided for Goole District Hospital only includes middle grade doctors.

- Diana, Princess of Wales Hospital: 100%
- Scunthorpe General Hospital: 98%
- Goole District Hospital: 100%

Diana, Princess of Wales Hospital had a bank staff usage rate of 18%, a locum staff usage rate of 81% and 0.3% of shifts were left unfilled.

Scunthorpe General Hospital had a bank staff usage rate of 20%, a locum staff usage rate of 78% and 2% of shifts were left unfilled.
Goole District Hospital had a bank staff usage rate of 14%, a locum staff usage rate of 86% and no shifts were left unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical)

Critical care had a designated clinical lead. Since the last inspection the challenges remained in terms of recruitment of consultant intensivists, at the time of inspection there were seven in post. A consultant was available during the day from 8am to 8pm supported by two junior doctors who worked from 8am to 6pm. Overnight cover had the same arrangement however the medical staff also had responsibility for theatres and obstetric emergencies. This meant GPICS recommendations were not fully achieved. However, all the nursing staff we spoke with confirmed a consultant was always available when needed, including out of hours.

It was also identified that consultant work patterns did not provide continuity of patient care as block working was not in place. This was also not in line with GPICS recommendations. We discussed this with the service leads as this had been noted at the previous inspection. The team were clearly sighted on this. There was active ongoing recruitment to explore all avenues to fill vacancies.

In the eight patient records we reviewed we saw that twice daily consultant led ward rounds took place from Monday to Thursday. Daily ward rounds took place on a Friday and at weekends. This was unchanged from the last inspection and not fully compliant with GPICS recommendations. The consultant to patient ratio was in line with the recommended range of 1:8 to 1:15.

Medical cover on the HDU from 8.30am to 5pm Monday to Friday was provided by a staff grade doctor who was based on the unit. Cover out of hours was provided by the on call medical registrar. A daily ward round took place Monday to Friday by the intensive care consultant and the respiratory consultant. If required the intensive care consultant would return in the evening.

In the 12 months prior to inspection there had been no use of medical locums in critical care.

Records

On ICU nursing and medical records were stored in a trolley at the end of each bed space or outside the room of those patients requiring isolation. On the HDU records were stored securely in trolleys with keypad access. Information provided by the trust showed 82% of nursing staff in the service had completed information governance training, which was just below the trust target of 85%.

We reviewed 11 sets of nursing and medical records in detail looking at care plans and risk assessments. Nursing records were accurate, fully completed and in line with trust and professional standards. Care bundles and pathways were in use for pressure area care and indwelling lines. There was evidence in the notes we reviewed of holistic assessment which focused on details other than physical health needs, for example, mental health conditions.

Medical records were completed in line with trust and professional standards. We saw that patients were reviewed by a consultant within 12 hours of admission to critical care. This was in line with GPICS recommendations and was an improvement from the last inspection where a names and grades of staff were not printed so this could not be evidenced.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital. A daily critical care assessment form was completed and on discharge from the unit a summary document was completed. This was done electronically and viewed on the trusts electronic patient management system.
CCOT staff confirmed that discharge information was thorough with clear escalation plans for individual patients.

Medicines

We reviewed eight medicine charts and found these to be completed in line with trust and national guidance. Each of the medicine charts had been reviewed by the pharmacist and the allergy status had been completed. Five of the charts we reviewed had antibiotics prescribed; this was done in line with national guidance.

During our inspection we found stock medicines within the ICU and HDU were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records in both areas and saw that accurate records and checks were completed in line with trust policy.

Fridge temperature checks and temperature ranges had been completed daily in each area.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 up to the time of inspection there had been no never events at this site. For the same time period there had been one serious incident reported which met the reporting criteria set by NHS England from March 2017 to February 2018.

(Source: Strategic Executive Information System (STEIS))

The HDU reported 78 incidents, and the ICU reported 84 incidents between November 2017 and April 2018. One of these related to a patient death. Thirteen of were graded as moderate harm, with 54% of these related to pressure damage, the majority of which was noted on admission to HDU or ICU.

However, it was noted that for the same period there were a number of incidents related to the availability of pressure relieving mattresses on HDU. Nine incidents related to mattresses not being available and five related to faulty mattresses. We were told there were ongoing discussions with medical engineering to try and resolve these issues.

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. There were various mechanisms for feeding back and sharing learning from incidents. This included information on notice boards in the staff room and via email.

Safety huddles took place each day at 8am with ward managers from each ward/unit. This allowed information to be shared which could then be cascaded to each team.

We reviewed monthly departmental governance meeting minutes and found incidents were a standing agenda item. Team meetings were also used to share information and learning. Incidents were again a standing agenda item; however, managers reported attendance could be a challenge. We observed a learning lessons folder and posters which detailed significant incidents and any associated learning or changes in practice.
Approximately 30% of reported incidents related to pressure damage. Some staff we spoke with were aware that a number of incidents related to pressure, however no examples of learning or changes in practice could be articulated. We were not aware of any specific action plans related to pressure damage. One staff member told us the unit was considering trailing a different mask for non-invasive ventilation to reduce pressure damage to the nose and ears.

Allied health professionals we spoke with told us that incidents were a standing item on their team meetings. They also said they would also be informed by the senior nurses if there had been an incident related to their service.

The electronic incident reporting system included a prompt on the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. We saw information displayed in general areas on the duty of candour. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care. In the February 2018 performance report, we saw 100% compliance with duty of candour requirements.

Monthly critical care specific mortality and morbidity meetings took place, which was in line with GPICS recommendations. Feedback from consultants we spoke with was this process was embedded within the service. We were able to attend one of these meeting during our inspection, in which there was multidisciplinary attendance.

When the mortality and morbidity forum was established in 2015 a decision was made to review two cases with the lowest predicted mortality at the monthly meetings. Following further review of the standardised mortality rate for the year an upward trend was noted. Following this a decision was made to review of deaths within the hospital episode after admission to the ICU.

Structured judgement training was provided for consultants to undertake reviews; the process had been modified to meet the needs of critical care. There were plans for reviews to be undertaken by multiple reviewers to reduce bias and to involve the high dependency unit in the process by the end of May 2018.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Safety thermometer data was collected by the sister on the HDU, however up to date information was not displayed. The safety information board on the HDU was partially blocked by a trolley.

We reviewed safety thermometer data for HDU which showed between October 2017 and April 2018 the percentage of harm free care was between 83% and 86%. In May 2018 this had improved to 100% harm free care.

For the same time period on ICU harm free care varied from 80% to 100%.

Compliance with venous thromboembolism (VTE) assessments was also monitored on the trusts.
divisional performance dashboard. Information from January 2018’s report indicated 100% had been completed for this unit; this exceeded the trust target of 95%.

Is the service effective?

Evidence-based care and treatment

The unit’s policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). Information from the April 2018 department governance meeting minutes showed compliance against NICE guidance was 86%.

Policies and guidance were accessed on the trust intranet which was easy to navigate. There was a critical care hub which contained policies relevant to the unit. This was shared between the two sites. We did find that old policies were not archived so searches could bring up several versions of the same policy which could be confusing to staff.

We reviewed 16 other polices and found them to be in date with an author and review date. Copies of 34 different polices and guidelines were in folders at individual bed spaces. Six of these were identified as needing review, including, the sedation algorithm, delirium and the tracheostomy care bundle.

We saw evidence of screening for sepsis in the patient records we reviewed. At the previous inspection a new sepsis screening tool had been developed but was not in use. From reviewing records and speaking with staff we were assured this process was embedded. We were told an electronic sepsis screening tool was being trailed linked in with the launch of NEWS two, the latest version of early warning scoring.

Monthly data was collected on critical care outreach activity as part of CG50. CG50 relates to evidence-based recommendations on recognising and responding to deterioration in acutely ill adults in hospital. The information collected included, the number of referrals made and seen and the length of time taken to conduct an initial review. Data from April 2017 to March 2018 showed that 86.5% of critical care patients were followed up and 99.7% of new ward referrals were visited.

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

From speaking with staff, we found that delirium screening was not taking place on HDU; this was also evident from the patient records we reviewed. However, we found this was being done in ICU and this was supported by the patient records we reviewed.

There had been a focus on care being delivered in line with NICE CG83 rehabilitation after critical illness since the previous inspection. Leaflets had been produced for patients and relatives and results of notes audits had highlighted the need for a short and comprehensive assessment tool. There were trials ongoing and changes being made to the assessment forms to make them user friendly whilst still capturing the required information. The current document had been streamlined and combined with physiotherapy documentation, we were told the initial feedback reading this revised document was positive.

Nutrition and hydration

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw this had been completed in the 11 patient records we reviewed.
The unit had a decision tree for nasogastric tube placements in adults and a standard operating procedure for checking placement by x-ray if normal processes are not available. There was access to an emergency feed protocol, this provided guidance for staff on feeding patients who were unable to eat and needed to be fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.

There was access to a dietitian and they would attend the unit each day. We observed them reviewing patients during our inspection.

During our inspection we saw that water was available for those patients able to drink. Assistance was provided as required for those patients able to eat and we found fluid balance charts were fully completed in each of the records we reviewed.

Pain relief

There was access to an acute pain team to provide advice; they worked with the multidisciplinary team. Pain relief was discussed on ward rounds and reviewed by the pharmacy team.

From the notes we reviewed we found evidence of pain scores being completed and appropriate action taken in response to any indication a patient was experiencing pain. Pain observation tools were available for patients who could not verbalise they were experiencing pain.

The patients and relatives we were able to speak with reported pain control being effective and that it was provided in a timely way.

Patient outcomes

ICNARC Participation

ICNARC data was collected by a data clerk who worked closely with the clinical team to collate information. At the time of inspection, the data clerk post for HDU was being advertised and temporary cover was in place.

The trust had two units, across two sites which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 annual report. The critical care minimum data set was also collected for theatre recovery.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Diana, Princess of Wales Hospital

Hospital mortality (all patients)

For the intensive care unit at Diana, Princess of Wales Hospital, the risk adjusted hospital mortality ratio was 1.2 in 2016/17. This was within the expected range compared to the England average. The figure in the 2015/16 annual report was 1.1.

We reviewed data from the 1 April 2017 to 31 December 2017 quarterly quality report, this showed the risk adjusted hospital mortality was 1.18, this was within the expected range.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low risk patients)

For the intensive care unit at Diana, Princess of Wales Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.3 in 2016/17. This was within the expected range compared to the England average. The figure in the 2015/16
annual report was 0.7. We reviewed data from the 1 April 2017 to 31 December 2017 quarterly quality report, this showed the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.42, this was within the expected range.

The unit had an unplanned readmission rate within 48 hours of 1.4% for the period of 1 April 2017 to 31 December 2017. This was lower (better) than the rate for similar units which was 1.6%, and was within the expected range when compared to the England average.

The physiotherapy team completed a national rehabilitation outcome measure called the ‘Chelsea Critical Care Physical Assessment Tool’, a scoring system to measure physical morbidity in critical care patients.

**Competent staff**

**Appraisal rates**

**Diana, Princess of Wales Hospital**

The appraisal completion rate for staff within critical care at Diana, Princess of Wales Hospital was 69.4%, lower than the trust target of 95%.

A split by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>39</td>
<td>58</td>
<td>67.2%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>62</td>
<td>69.4%</td>
<td>No</td>
</tr>
</tbody>
</table>

Some of the nursing staff we spoke with confirmed they had undergone a recent appraisal. This was supported by up to date appraisal data we were provided with which showed compliance for nursing staff on HDU was 62%. Compliance for nursing staff on ICU was 69%. These figures were below the trust target of 95%.

We requested appraisal data for medical staff. This showed that compliance was 79%.

Information provided by the trust showed that 12% of nurses in ICU had a post registration award in critical care nursing. This was a reduction from the last inspection where it had been 49%. On HDU the number was significantly lower at 4%. This was a consequence staff vacancy and turnover rates and was not in line with the GPICS minimum recommendation of 50%. All staff on HDU had completed an in-house, six week long high dependency nursing course.

Since the previous inspection a clinical educator had been appointed for this site, to cover ICU and HDU. The clinical educator was collating training information to enable oversight of training and staff competence.

Historically local competency documents had been used and it was identified there was still a lack of external training opportunities. Five new staff to the unit were working to complete the national competency framework for adult critical care nurses with a local university. Information was also captured on training for specific equipment such as the new ventilators and hemofiltration. However, it was difficult to be assured around overall compliance as information was not stored on a central database or spreadsheet but in a number of different documents. Training for new equipment would often be delivered by company representatives, cascade
training would then occur. We were told for the new ventilators a competency document had initially not been available, however it was then provided by the company. The majority of staff (39 out of 48) had been assessed as competent to use the ventilators, and there were plans to ensure the remaining staff were trained.

GPICS guidance states staff transferring patients between hospitals should have relevant training additional to that of transfer training within the hospital. This ensures staff are competent to use the equipment and manage any deterioration which may occur on route. We were provided with training data. This showed 77% of staff were trained in transfers, however only 4% had been trained externally. There were plans for staff to attend training; however, this information along with other training compliance did not feed in to the staff rotas. We therefore were not clear how the units could assure themselves that there were appropriate skill mix on each shift. Several staff we spoke with highlighted that whilst the number of staff on duty was appropriate the mix of skills and competence was sometimes a concern.

Staff within the deteriorating patient team and the clinical educator played a key role in delivering training, for example the ALERT course which had been locally adapted and tracheostomy training.

At the previous inspection staff rotated between the HDU and ICU. A small number of staff had rotated from HDU to ICU; however, there was no formal rotation programme in place.

All new staff both medical and nursing attended a corporate induction when starting at the trust. A local induction was completed by all new staff. There was a preceptorship programme in place and new staff would initially be supernumerary and were allocated mentors to work alongside. We spoke with some new staff members who said they felt well supported in their role.

**Multidisciplinary working**

We observed good multidisciplinary team working; this was supported by the staff we spoke with. We saw evidence of this in the patient records we reviewed. There was a lead pharmacist, physiotherapist and dietitian for critical care. Access to speech and language therapy, a specialist nurse in organ donation and other nurse specialists was available when required.

There were clear internal referral pathways to therapy and psychiatric services.

Multidisciplinary staffing was generally in line with GPICS recommendations; however, it did not meet the full recommendations. There was not always full attendance during ward round however we saw from reviewing records there was daily input from the pharmacist and dietitian. We spoke with physiotherapy staff who confirmed that in line with GPICS recommendations they were able to provide the respiratory management and rehabilitation components of care.

Microbiology input was variable; there was one consultant available five days a week. They were available as needed, but this may have been by telephone rather than in person. If this person was on leave access to microbiology advice was via a clinical pathology network operating across Lincolnshire.

We reviewed the units’ admission and discharge policy. This outlined the criteria for admission to the unit. We observed handovers taking place and the completion of transfer documents for patients going to ward areas. This was in line with NICE CG50 acutely ill adults in hospital. The critical care outreach team followed up all patients discharged to the wards from intensive care.
Seven-day services

We saw from patient records daily consultant led ward rounds took place. However, as discussed in the medical staffing section, this was not in line with GPICS recommendations, due to a lack of consultant intensivists.

A specialist critical care pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patients’ medicines. There was access to pharmacy provision on call at other times.

Physiotherapists provided treatment seven days a week with an on-call service was available overnight.

X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

Health promotion

Staff completed assessments on admission to the unit about patients’ individual needs and provided support as appropriate.

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The staff we spoke with demonstrated some understanding of the mental capacity act and deprivation of liberty safeguards. However, not all staff knew how capacity would be assessed and where this would be documented.

Data was requested following the inspection on mental capacity training compliance for nursing and medical staff. The information provided by the trust showed 85% of nursing and 68% of medical staff were compliant with MCA training.

Staff we spoke with demonstrated a good understanding of consent, and where possible, would always seek consent from patients. On HDU we observed verbal consent being taken before procedures were undertaken.

In the records we reviewed there were daily prompts to undertake Richmond Agitation-Sedation Scale (RASS) scores and screening using the Confusion Assessment Method (CAM) for ICU. These are used to measure the agitation, sedation or delirium levels of a patient. We saw that where appropriate these had been completed and appropriate actions taken. These tools were not used in HDU.

We spoke with staff about the use of restraint. Staff we spoke with told us where possible this would be avoided, however staff explained the process they would follow for the use of restraint and that they would complete an incident form. This was in line with trust policy and from reviewing incident data we saw this had been done.

Is the service caring?

Compassionate care
The patients and relatives we were able to speak with were consistently positive about the care given. Feedback was that staff were caring and compassionate to both patients and their relatives. The exception to this was one relative who said staff had not introduced themselves and they were not aware of what was happening.

We observed all members of staff providing care for patients' in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious.

On HDU we observed buzzers being answered promptly and patients we were able to speak with confirmed a timely response to any calls for assistance.

During this inspection both units were busy, we observed staff calmly providing patient care and attending to the needs of their patients. The privacy and dignity of patients was maintained when care and treatment was being delivered by pulling curtains round.

We saw thank you cards and friends and family test data for April 2018 displayed on the ward information board in HDU which showed 100% of respondents would recommend the service. We did not see thank you cards publicly displayed on ICU.

**Emotional support**

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients. Contact information on this was seen at the nurses’ station.

The critical care outreach team said part of their role when reviewing patients on the ward following discharge from the unit was providing psychological support. Specialist nurses were also available to provide advice and support.

Staff we spoke with felt able to provide support to relatives and well as to patients and felt this was an important part their role.

Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life.

**Understanding and involvement of patients and those close to them**

At the Scunthorpe site we saw a guidance document had been produced for staff to support use of patient diaries. We did not see this at this site. We saw limited use of patient diaries during the inspection.

We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.

The relatives we spoke with said they were involved in care plans and knew what was happening and what to expect. Most told us they were given daily updates from staff. One set of relatives described the communication as ‘excellent’.

We observed medical and nursing staff taking time to explain what was happening to relatives so they understood the care and treatment.

Staff we spoke with knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff had access to a specialist nurse for organ donation.
Is the service responsive?

Service delivery to meet the needs of local people
Critical care provision on the ICU flexed to meet the differing needs of level two and level three patients. The HDU provided level two care, there were clear pathways between the units if patient care needed to be stepped up or down.

The critical care outreach team reviewed all patients who were discharged from intensive care to ward areas.

There was a coffee room for relatives on ICU, however some relatives commented it was not possible to get food through the night or in the evening. There were no facilities on either unit for relatives to stay overnight.

The service did not have a critical care patient and relative support group.

The service had a follow up clinic in place. Patients were offered an appointment three months after discharge from the unit. The clinic was run by the critical care outreach team; if patient needs were identified referrals were made via their general practitioner. We were told the service was looking at providing consultant involvement with follow up clinics; however, no timeframes had been set to implement this.

Meeting people’s individual needs
Staff we spoke with knew how to access translation services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available.

Staff we spoke with felt confident to care for patients with a learning disability or living with dementia. We saw evidence in patient records that care plans included assessment and interventions for any patients with additional needs. This information would be communicated to all staff during handovers.

Staff recognised the importance of relatives and carers for any patients with additional needs. Staff would seek support from the nurse in charge if they had any concerns, or they could access specialist nurses.

The patient records that we reviewed reflected that individual needs were assessed and care planning was informed by this.

Staff were encouraged to complete patient diaries for level three patients and any other patients who stayed on the unit for more than 72 hours. We found the use of these was not embedded amongst staff. Evidence has shown these can provide comfort for patients following a stay on an ICU as they can fill in gaps and help patients understand what they have experienced.

Staff we spoke with told us they could access equipment to care for bariatric patients and this was always available when needed.

Access and flow

Bed occupancy
From January to December 2017, Northern Lincolnshire and Goole NHS Foundation Trust has seen adult bed occupancy slightly higher than the England average for the majority of months in
the period.

**Adult critical care Bed occupancy rates, Northern Lincolnshire and Goole NHS Foundation Trust.**

![Graph showing bed occupancy rates](image)

Please note, data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

**Delayed discharges**

For the intensive care unit at Diana, princess of Wales Hospital, there were 2,373 available bed days in 2016/17. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 1.8%. This compares to the national aggregate of 4.9%, indicating that the unit was not in the worst 5% of units nationally. The figure in the 2015/16 annual report was 4.8%.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

We were provided with the most recent ICNARC quarterly quality report. This showed that between 1 April 2017 and 31 December 2017 the bed days of care post eight-hour delay rate was 2.6% this was better than similar units which had an average of 3.2%.

We asked staff about the process for when a patient was declared fit to transfer to a ward and staff told us they were proactive in managing this. If issues arose the matron could be contacted for support.

**Non-clinical transfers**

For the intensive care unit at Diana, Princess of Wales Hospital, there were 409 admissions, of which 2.7% had a non-clinical transfer out of the unit. Compared with other units, non-clinical transfers for this unit was worse than expected. The figure in the 2015/16 annual report was 2.3%.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

ICNARC data from 1 April 2017 to 31 December 2017 showed that of 307 admissions to this unit there were four non-clinical transfers (1.3%); this was slightly higher than similar units who reported a rate of 0.9%. However, as the graph below shows this was an improving picture, and a reduction since the last inspection.
Non-delayed out of hours discharges to the ward

For the intensive care unit at Diana, Princess of Wales Hospital there were 70 admissions of which 5.7% was non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, the unit’s performance was within the expected range. The figure in the 2015/16 annual report was 7.3%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The decision to admit to the unit was made following a discussion between the critical care consultant and the consultant or doctors already caring for the patient. From the notes we reviewed all the patients had been reviewed by a consultant within 12 hours of admission. This met the GPICS standard.

On HDU we observed two male and one female patient in one bay and two female and one male patient in the other. It was felt that mix sex accommodation could have been managed more proactively although it was recognised that the unit could have a quick patient turnover.

Learning from complaints and concerns

Summary of complaints

Critical care services at Diana, Princess of Wales Hospital received six complaints, four about patient care, one about communication and one complaint in relation to appointments. The unit took an average of 51 days to investigate and close complaints, which is not in line with the trust complaints policy which states that complaints should be closed within 30 days, or the trust’s further target of 45 days.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Information was available to patients and relatives on how to make a complaint. Staff we spoke with were aware of the policy for managing concerns. However, all staff said they would try and resolve any concerns at the time they arose. Often this may be dealt with by the nurse in charge.

Complaints and information from the patient advice and liaison service were standing agenda items on the departmental governance meetings. We reviewed minutes from January 2018 to April 2018, there were no areas of concerns identified which related to critical care.

Is the service well-led?

Leadership

At the previous inspection there had been changes to the senior management team, since then there had been further changes. Clinical directors had been appointed and had oversight of the
directorates, they were supported by an operational director and operational chief nurse. These changes supported an improvement in clinical oversight and ownership. The team we spoke with were positive about the changes and felt even prior to the changes they had been working towards this model.

There was a lead consultant and a lead nurse for critical care. Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards.

From discussions with the leadership team it was clear they understood the current challenges and pressures impacting on service delivery and patient care. There were plans in place to address gaps and areas of non-compliance with GPICS standards, however the team accepted the significant challenges with regards to medical staffing.

We received mixed feedback from staff about the visibility and availability of senior nursing staff. There was strong medical leadership on the units. From our observations and from speaking with staff, it was clear that not all staff had confidence in the nursing leadership. Some staff we spoke with reported feeling very supported by their teams and managers and able to escalate any concerns, however this was not the opinion of all staff we spoke with.

Senior nurses were extremely positive about the service and very proud of all the staff and the quality of the care they provided for their patients and families.

**Vision and strategy**

The vision for the unit was ultimately dependent on the long-term reconfiguration of critical care services across the two hospital sites of Scunthorpe and Grimsby. The leadership teams hope was for a combined unit with additional capacity at this site.

The staff we spoke with were generally not aware of the vision and strategy for the units.

We spoke about the strategy for the service with the senior management team and were provided with the critical care future configuration options appraisal which formed the emerging view of the trusts critical care strategy. This was based on a review of data to inform what future services would need to look like to support patients requiring critical care admission.

The information in the document showed an understanding of the local and wider critical care requirements and the options considered were based on a review of activity within the two units.

There was and continued to be a focus on CG83, guidance on rehabilitation after critical illness, as well as looking at the completion of staffing competencies and developing the skills of the workforce.

There was also a focus on access and flow to continue to try and reduce out of hours discharges and non-clinical transfers from the unit.

**Culture**

Staff we spoke with told us they felt proud of their work and the care they provided to patients and their relatives.

All staff we spoke with told us they felt able to raise concerns and were aware of the importance of being open and honest to patients and relatives if there had been a mistake in their care.

Whist we found morale within the nursing team on HDU was generally good, we found one area causing dissatisfaction amongst staff was movement to other areas. This was also found at the previous inspection. Staff on ICU also spoke about this to the inspection team. Staff raised
concerns about how the decision to move staff was communicated to them by the site management team and that they could be left in charge of an area they were not familiar with. We found incident data to support this, two of which made reference to the communication style of the site co-ordinators when they requested the critical care nursing staff to move to another clinical area. We spoke about this with senior nursing staff and a meeting was due to be held to try and resolve some of these issues which staff we spoke with saw as a positive step.

We found morale on ICU was mixed. This was further reflected in staff members’ approach and responsiveness to training. It had been identified some staff were reluctant to update their training and competence and did not recognise the importance of this. There was also a lack of ownership in terms of individual professional development for some staff. These concerns had been escalated and were being managed by the senior nursing team.

Some staff fed back that the lack of continuity of consultant cover led to some inconsistencies in terms of decision making and at times meant they had to provide additional support to families as a consequence of this.

**Governance**

Governance processes had changed since the last inspection, whilst these were still relatively new, it was felt this positive and that governance would be strengthened.

The directorate had established a surgical management board. This was clinically led with each speciality giving an update so each one was sighted on each other’s issues. Weekly meetings also took place between the business manager, the matron and the clinical lead for critical care. We reviewed meeting minutes which had standing agenda items related to risk, incidents and complaints.

The information was disseminated to staff via team meetings, however it was identified that attendance had been poor. Managers were reviewing when meetings took place to try and improve attendance.

Information was also shared at safety huddles which took place each morning after handover. These took place off the units and were attended by all ward managers or a deputy.

**Management of risk, issues and performance**

There was a divisional risk register which contained 45 risks; four of these were specific to critical care at this site. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. Each of the risks had been reviewed and updated in December 2017. There was a description of the risk with associated controls and action plans.

The risks related to consultant staffing, hemofiltration equipment needing replacement, capacity within the outreach service to provide a twenty-four-hour, seven day a week service and the temporary relocation of ICU.

From our discussions with the leadership team they were clear about any risks to the service and mitigating actions and the risk register reflected this.

The previous inspection had found some gaps in terms of rehabilitation following critical illness. Within the unit there had been a significant amount of work to improve this. Work was also ongoing with regards to clinical assessments and how best to capture this information. There were also plans to try and have medical input into the follow up clinics. Further work was needed to ensure patient diaries were being completed.
Dashboards for deteriorating patients and sepsis were in place. This allowed for monitoring and targeted interventions based on the data.

**Information management**

The admission, discharge and transfer documentation was in line with best practice and NICE guidance.

Staff received training on information governance and were aware of the importance of managing confidential patient information. We found that records were stored securely within the unit.

Blood results, x-rays and scan results could be accessed electronically, mobile workstations allowed these to be reviewed at the patients’ bedside.

**Engagement**

Friends and family test data as for all critical care units was limited, so results could not be collated or analysed. A listening into action had been implemented called ‘making feedback count’. The aim was to capture feedback from patients to support changes and improve service provision.

A questionnaire was designed with input from staff with a collection box on the unit. The responses were collated in to a spreadsheet to enable any themes to be identified. In response to this the unit is looking to purchase a mobile hydration station for relatives.

Some feedback was gained from the follow up clinics and through patient diaries. However as described these processes were still being further embedded.

We received mixed views in terms of staff feeling involved and informed about what was happening in the trust. The ICU and HDU were in different locations within the hospital. There was limited inter-unit interaction.

We reviewed meeting minutes which evidenced discussions around incidents, training and staffing with senior staff. We saw some notice boards that were used to share information safety information, however these did not appear to be up to date.

**Learning, continuous improvement and innovation**

The service was actively involved in the regional critical care operational delivery network.

A significant amount of work had been done on rehabilitation after critical illness and this work was ongoing.

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

Local safety standards for invasive procedures (LocSSIPs) had been developed for central venous access devices. A database was also held of all central lines inserted to provide oversight and monitoring.

The trust was an early implementer of the NEWS two pathway, which provides improved safety and clinical outcomes for acutely ill patients.
Training that had been provided by the critical care service for 20 paramedics of a local ambulance trust in taking blood cultures and administering intravenous antibiotics. This initiative had received recognition by the UK sepsis trust.
Services for children and young people

Facts and data about this service

Details of children and young people’s services

The trust has 70 inpatient paediatric beds across its two sites:

- Diana, Princess of Wales Hospital has 18 inpatient beds, including two high dependency beds, on Rainforest Ward. There are also 18 cots, including six transitional care cots, on the neonatal unit.

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute tab)

The trust had 3,775 spells from December 2016 to November 2017.

Emergency spells accounted for 95% (3,584 spells), 4% (152 spells) were day case spells, and the remaining 1% (39 spells) were elective.

Percentage of spells in services for children and young people by type of appointment and site, from December 2016 to November 2017, Northern Lincolnshire and Goole NHS Foundation Trust.

Total number of children’s spells at trust level and by site, Northern Lincolnshire and Goole NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>2,049</td>
</tr>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>1,720</td>
</tr>
<tr>
<td>This trust</td>
<td>3,775</td>
</tr>
<tr>
<td>England total</td>
<td>1,099,209</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)
The children’s services at Diana, Princess of Wales Hospital included an 18-bed inpatient ward, a 12 cot neonatal unit, six transitional care cots, a paediatric outpatients department, a child development centre and a children’s assessment unit.

Is the service safe?

Mandatory Training

Mandatory training was available in subjects such as infection control, manual handling, equality and diversity, fire safety and conflict resolution. Some training was completed face to face but a number of courses were completed online.

During our inspection, we spoke with ward managers who told us that the central training system showed that staff required training even after they had completed the training. The ward managers emailed staff training certificates to the central team and the central team uploaded these on to the system. This meant that there were some delays between the training that had been completed and showing as completed on the system. This had been escalated as an issue up to board level in the last three months. Some ward and department managers kept their own local records of staff attendance at training.

Staff told us that on the training matrix they received there were training courses identified as needing to be completed that were inappropriate for the staff to complete. A change in the resuscitation training for the paediatric and neonatal nurses meant that all staff were identified as requiring resuscitation training despite them having completed the previous training. Staff were booked on to the new training.

Managers we spoke with told us that the majority of their staff were up to date with mandatory training, those staff that were not were on maternity leave or sick leave.

During our last inspection, we found that staff were not meeting the targets for mandatory training. The training figures below were provided by the trust prior to our inspection. These show that medical staff did not meet the target for compliance, whilst nursing staff met the target in five subjects.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for medical staff in services for children and young people is shown below:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>23</td>
<td>28</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>22</td>
<td>28</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Medical and dental staff at the trust did not meet the completion target for any of the courses.

A breakdown of compliance for mandatory courses February 2017 to January 2018 for qualified nursing and midwifery staff by site is shown below:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>55</td>
<td>56</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>55</td>
<td>56</td>
<td>98%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>51</td>
<td>56</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>28</td>
<td>31</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>49</td>
<td>56</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>49</td>
<td>56</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>42</td>
<td>56</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>38</td>
<td>56</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>38</td>
<td>56</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>38</td>
<td>56</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 85% training target was met for six of the 10 modules offered to nursing staff at Diana Princess of Wales Hospital.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Following our inspection, we requested up to date mandatory training figures for April 2017 to March 2018. These showed that overall compliance with mandatory training within children’s services at the trust was 65% for medical staff and 83% for nursing staff. However, these figures were not broken down by site or subject. Medical staff in children’s services were therefore not meeting the trust target of 85% compliance for mandatory training.

Safeguarding

There was a children’s safeguarding team, which consisted of a named doctor, named nurses and specialist nurses for safeguarding children. A safeguarding children forum was held two monthly and this fed in to the quality and safety committee, which in turn fed in to the trust board.
Staff we spoke with told us that the safeguarding team visited the wards/departments. The safeguarding team were accessible and staff contacted them for advice when needed. The Royal College of Nursing Guidance: Safeguarding children and young people – every nurse’s responsibility (2014), states that regular high-quality safeguarding supervision is an essential element of effective arrangements to safeguard children. Staff attended safeguarding supervision sessions held by the safeguarding named nurse. On the neonatal unit, safeguarding supervision sessions were held monthly for staff to attend and supervision could be accessed ad hoc when staff needed to discuss a current case. Following our inspection, we requested evidence from the trust of staff attendance at safeguarding supervision. For medical staff we saw that nine out of 27 were not up to date with their safeguarding supervision. We did not receive any evidence related to nurse staffing attendance.

Staff we spoke with were able to describe the process they would follow if they had any concerns about a child or young person. We saw a clear safeguarding pathway and protocol.

We reviewed safeguarding policies available to staff. These included a Safeguarding Children policy, Safeguarding Supervision policy, Domestic Violence policy and a Management of Children and Young People Who Are Not Brought to Outpatient Clinics policy. All polices were in date and were clear and comprehensive.

Ward areas were secure, with access via an intercom. However, in the paediatric assessment unit there was free access from the accident and emergency department in to the assessment unit, meaning that anyone could walk in to the department. This issue had been highlighted to the trust following a recent Clinical Commissioning Group (CCG) visit. We spoke to staff about this and they told us that it was used by staff to access the unit, there did not appear to be any plans to secure the doors. The doors in to the main corridor were locked but they did not have intercom access and it was therefore possible that another parent or child on the unit could open the door for someone to access the unit.

On admission, staff asked the parents/carers whether a social worker was involved with the child’s care. However, there was some confusion from staff we spoke with as to whether they would be able to tell on admission whether the child was on a child protection plan, without the parents telling them. There was a flagging system in the electronic record, for those children on child protection plans or who were looked after children. However, as the record was not used as an electronic patient record, it was unclear whether staff would look at this on admission, as when questioned about a flagging system for child protection or looked after children, staff we spoke with did not seem sure.

We reviewed three sets of records that related to safeguarding concerns. We saw that appropriate referrals were made and safeguarding paperwork had been completed. Safeguarding forms were used for specific concerns such as bruising, fractures and child sexual exploitation (CSE).

The intercollegiate document, Safeguarding Children and Young People: Roles and competencies for Health Care Staff (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level three in safeguarding. The training figures below were provided by the trust prior to our inspection.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical staff in services for children and young people is shown below:
At Diana, Princess of Wales Hospital, the target was not met for any of the four modules.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for qualified nursing staff in services for children and young people is shown below:

**Diana, Princess of Wales Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>11</td>
<td>14</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>22</td>
<td>29</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>21</td>
<td>28</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>18</td>
<td>28</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Diana, Princess of Wales Hospital, the 85% target was not met for safeguarding adults level one or safeguarding children level three. However, the level three safeguarding training compliance was at 84%, which was nearly at target compliance.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

Following our inspection, we requested up to date safeguarding training level three figures. The trust provided the information below to show that between April 2017 and March 2018, compliance was:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>No</th>
<th>Yes</th>
<th>Grand Total</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>208 DPOW Critical Care Ward Nicu (2450)</td>
<td>4</td>
<td>30</td>
<td>34</td>
<td>88%</td>
</tr>
<tr>
<td>208 DPOW Medical Staff Neonatal (3622)</td>
<td>2</td>
<td>2</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>208 DPOW Medical Staff Paediatrics (3617)</td>
<td>2</td>
<td>15</td>
<td>17</td>
<td>88%</td>
</tr>
<tr>
<td>208 DPOW New Born Hearing Screening (2452)</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>208 DPOW Paediatric Nursing Community and Outreach</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Medical staff on the neonatal unit were therefore not meeting the trust target for compliance with level three safeguarding training.

### Cleanliness, infection control and hygiene

All areas we visited were visibly clean. Equipment had ‘I am clean stickers’ to indicate that cleaning had taken place. We saw records to indicate that cleaning of toys had taken place.

Hand gels and hand washbasins were available in every area and we saw staff washing their hands appropriately. Personal protective equipment, such as aprons and gloves were available and used by staff. We saw staff complying with the arms bare below the elbows policy.

Hand hygiene audits between April 2017 and April 2018 for the children’s ward, showed 100% compliance for most months apart from April 2017 when compliance was at 75%, in November 2017, compliance was at 50% and in April 2018, compliance was at 83%. There were no results available for the paediatric assessment unit for 2017, but in April 2018, compliance was 100%. The children’s outpatient department had achieved 100% compliance between April 2017 and April 2018. The neonatal unit achieved 100% compliance in most months, apart from July and August 2017 and January and April 2018, when compliance was between 91.5% and 96%.

Local cleaning audits showed that all areas were meeting the target of 95%

Staff attended infection control training. However, compliance was below the trust target of 85% with 68% of nursing staff and 46% of medical staff having completed the training.

On the neonatal unit, we saw two cubicles where the babies were nursed under infection control precautions and the doors had been propped open. Staff told us that they had the doors open in order to hear the babies and the monitors.

Babies admitted to the neonatal unit were screened for MRSA within 24 hours of admission and weekly thereafter.

The children’s ward had two isolation cubicles that had ensuite bathrooms. We saw medical staff entering these cubicles using the gloves and aprons provided and restricting the number of people who entered the cubicle.

Disposable curtains were clean and had the dates they were changed visible.

There had been no cases of MRSA or *clostridium difficile (C.difficile)* for children’s services between April 2017 and February 2018.

### CQC Children and Young People’s Survey 2016

In the CQC Children and Young People’s Survey 2016 the trust scored 8.8 out of 10 for question 6, ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts. This question was asked of parents and carers of children up to 15 years of age.
Environment and equipment

The children’s assessment unit was collocated next to the accident and emergency department. This was in a separate building to the children’s ward and neonatal unit. The children’s outpatient department and child development centre were located in the same building, which was next to the women and children’s building. All areas were bright and child friendly.

Children undergoing surgery were cared for on the children’s ward. At our last inspection, it was identified that the environment for paediatric surgery did not comply with national guidance. The Royal College of Surgeons Standards for Children’s Surgery (2013) say that ‘as far as possible, adults and children are segregated in all service areas. Where this is not possible arrangements are made that recognise the needs of children and their carers’. There was not a dedicated paediatric theatre but staff did ensure paediatric patients were at the start of the theatre list.

Service leads told us they were looking at the possibility of having separate paediatric theatre lists. There was a separate children’s waiting area in the theatre area, which had washable toys, books and a television. The recovery area was shared with adult patients but there was a dedicated space for paediatric patients and they were screened from adult patients by a curtain. A children and young person’s charter was on display, which said that ‘children will not pass other patients when coming out of recovery’. There was also a notice on the post anaesthetic care unit door, which said that paediatric nurses should collect paediatric patients via the main reception.

All equipment we saw had up to date safety testing. Staff we spoke with told us that they had no problems obtaining equipment. However, staff in the child development centre told us that if they needed to order equipment for children at home there was only one person that dealt with the ordering, which could cause a delay if that person was off sick or an annual leave.

Resuscitation equipment was available on the children’s ward and in the outpatient’s department. The child development centre was located next to the children’s outpatient department and used their resuscitation trolley, if needed. The paediatric assessment unit did not have its own resuscitation trolley and had to use the paediatric trolley that was situated in the accident and emergency department. We went in to the accident and emergency department and found that the paediatric resuscitation trolley was situated quite a distance away from the paediatric assessment unit. This had been highlighted in a recent CCG visit. Staff on the assessment unit told us that there were plans in place for the assessment unit to receive its own resuscitation trolley but we were not given a timescale for this. The assessment unit had a bag and mask for resuscitation and drug boxes containing medicines for resuscitation on the unit.

Resuscitation trolleys were sealed with a tamper proof tag. However, these tags were not numbered and it was therefore possible that an unauthorised person could access the trolley and replace the tag without staff been aware. We saw completed checklists for the checking of resuscitation equipment.

At a recent CCG visit, they had highlighted concerns with access to the kitchen on the children’s ward and the potential for children to be able to access this area. During our inspection, we saw that the doorway to the kitchen area was protected with a safety gate, therefore preventing children accessing this area.

On the neonatal unit there was a fridge for the storage of breast milk, this had been highlighted as a risk at our last inspection as it was not locked and there was free access to the contents. At this inspection, we saw that the fridge was still unlocked but it had been risk assessed and bottles were fitted with tamper proof labels, this ensured that staff and parents could see if anyone had accessed the bottles.
A recent neonatal peer review had identified restricted space around the cots in the intensive care bay on the neonatal unit; action had been taken following this by reducing the number of cots in the room to three instead of four.

We saw that the children’s community nursing team kept a record of all equipment held at home and when the service was next due. The healthcare assistant checked the list weekly and ensured that equipment was tested as needed.

**Assessing and responding to patient risk**

The children’s ward and paediatric assessment unit used a paediatric early warning score (PEWS) to highlight when a child’s condition was deteriorating. This tool included guidance on what action to take in the case of escalating scores. At our previous inspection, the tool did not provide a numerical scoring system to prompt staff to a child’s deteriorating condition. At this inspection, a new tool was in use which used a numerical scoring system and the service was about to pilot an electronic version of the tool.

We reviewed eight sets of records and saw staff had recorded PEWS scores accurately and followed appropriate escalation and medical review. PEWS scores did not contain the temperature; this was recorded separately.

The neonatal unit used a newborn early warning trigger and track (NEWTT) system for those babies in transitional care. This system identified deterioration in healthy but ‘at risk’ babies. We saw these used effectively to monitor and assess risk.

Paediatric sepsis screening tools were available for staff to use. In two sets of records, we saw appropriately completed sepsis screening tools. In one set of records, where a child had developed a high temperature, there was no sepsis screening tool used, however the child did not have an elevated PEWS score.

The children’s ward had two high dependency beds where children needing a higher level of care, such as high flow oxygen or continuous positive airway pressure (CPAP) were cared for. We were told that the nurse practitioner taught staff in the care of these children and we saw a critical care skills competence package. Some of the staff had done high dependency courses, but the staff we spoke to were unsure how many staff had undertaken a course. We requested evidence from the trust for staff competencies, however they only sent us information related to Scunthorpe hospital and not Diana, Princess of Wales hospital.

The service accessed support and guidance from the regional paediatric transport service for critically ill infants and children. This service transferred critically ill children to the nearest available paediatric intensive care unit. When we asked staff whether they had an escalation or transfer policy, they told us they did not have one. However, we were provided with these policies when requested from the trust. Staff told us a patient awaiting transfer would be nursed on the ward in a high dependency bed and if they were ventilated an anaesthetist would stay with them. We saw appropriately completed risk assessments in patient’s notes, including for pressure areas, nutrition and venous thromboembolism (VTE).

There was no formal risk assessment tool used for those patients with a mental health concern but brief questions were incorporated on the main admission assessment, which was then
followed up by the local Child and Adolescent Mental Health Service (CAMHS). Staff told us that if they had young people with mental health concerns admitted they had good support from the local CAMHS team and if a young person needed close observation the CAMHS team could fund sitters to stay with the young person. Records reviewed showed that children and young people were not discharged until they had been assessed by CAMHS.

Safety huddles took place on the children’s ward and the neonatal unit. The huddles identified any children at risk of deterioration, number of staff and number of patients, any safeguarding concerns and any other issues that needed to be highlighted to staff.

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 7.7 out of 10 for question 20, ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts. This question was asked of parents and carers of children up to 15 years of age.

**CQC Children and Young People’s Survey 2016 questions, safe domain, Northern Lincolnshire and Goole NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q20. Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-15 adults = asked of parents and carers of children up to 15 years of age.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Nurse staffing**

There were no staffing vacancies in children’s services at Diana, Princess of Wales Hospital and staffing levels had been increased since our last inspection. However, the staff turnover was still high. When we spoke with the service leads, they told us that staffing levels were still not exactly where they wanted them to be and they had recently had a business plan for extra nursing staff approved.

A safer care nursing tool was used to measure the acuity and dependency of patients. This was completed three times a day to measure the safety of staffing in the clinical area.

The trust has reported their staffing numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan 18)</th>
<th>Actual WTE (Jan 18)</th>
<th>Planned WTE (Jan 17)</th>
<th>Actual WTE in month (Jan 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>41.4</td>
<td>43.4</td>
<td>41.4</td>
<td>42.5</td>
</tr>
</tbody>
</table>

The trust reported that across both sites 98.9% of qualified nursing posts were filled as of January 2017, and 99.5% as of January 2018. Diana, Princess of Wales Hospital was over established in both months.
Vacancy rates

Annual vacancy rates for qualified nursing staff in services for children and young people from February 2017 to January 2018 are shown below.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>-2*</td>
<td>41.4</td>
<td>-7.3%*</td>
</tr>
</tbody>
</table>

*Negative numbers indicate a staffing surplus

The trust reported staffing 3.7% above establishment for qualified nursing staff in services for children and young people, driven by a surplus of 7.3% at Diana, Princess of Wales Hospital. Both sites met the trust’s target of 6.3% for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Annual turnover rates for qualified nursing staff in services for children and young people from February 2017 to January 2018 are shown below, at trust level and by site. Please note, staff in the trust’s safeguarding and looked after children team were not mapped to a hospital site in the trust data and are shown here under trust wide.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>4.9</td>
<td>40.1</td>
<td>12.2%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>1.0</td>
<td>11.0</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 7.8% for qualified nursing staff in services for children and young people, which was lower than the trust’s target of 9.4%. Diana, Princess of Wales Hospital was the only site to not meet the trust target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Sickness rates for qualified nursing staff in services for children and young people from January 2017 to December 2017 are shown below.
The trust had an annual sickness rate of 4.9 for qualified nursing staff in services for children and young people, which was higher than the trust's target of 4.1%. Diana, Princess of Wales Hospital did not meet the trust target for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

The nursing agency and bank staff usage is shown below:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0 (0.0%)</td>
<td>52 (25.4%)</td>
<td>53 (25.9%)</td>
<td>205</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>97 (9.7%)</td>
<td>229 (22.9%)</td>
<td>207 (20.7%)</td>
<td>1,002</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018, 794 nursing shifts were filled by bank or agency staff in services for children and young people, which represented 38.3% of all available shifts. Over this period 22.8% of all shifts remained unfilled.

Over the same period at Diana, Princess of Wales Hospital a total of 378 nursing shifts were filled by bank or agency staff in services for children and young people, which represented 31.3% of all available shifts. Over this period 21.5% of all shifts remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The band seven ward manager worked Monday to Friday 8am to 5pm in a management role. However, if there were any staffing shortages then they would work clinically.

At our previous inspection, there was a lack of senior nursing cover with only two band six nurses employed on the children’s ward. Since then, a further three band six nurses had been employed and there was a band six nurse on every shift. The band six nurse worked supernumerary between 9am and 5pm, but would look after patients if patient dependency or staffing numbers needed them to.

We reviewed staffing rotas and bed occupancy for April 2018 and saw that the children’s ward was meeting the Royal College of Nursing (RCN) recommended ratios for staff to patients of one nurse to three patients under the age of two and one nurse to four patients over the age of two. A ratio of one nurse to two patients is recommended for those children nursed in the high dependency beds.

Staffing of the paediatric assessment unit had been identified as a concern at our last inspection. At this inspection, the staffing of the unit was still not in line with RCN guidance (2013), which says that there should be a minimum of two registered children’s nurses available throughout the opening hours. The unit was staffed with one registered nurse, one healthcare assistant and one
speciality doctor or advanced nurse practitioner.

The neonatal unit completed a workload and acuity risk assessment daily. These assessments helped to determine whether extra staffing was required. Planned staffing for the neonatal unit was for four registered nurses and two healthcare assistants. The unit manager told us that they were allowed to staff up to five registered nurses if needed.

We reviewed rotas for April 2018 and found that for three shifts out of 29, they were not compliant with the British Association of Perinatal Medicine (BAPM) guidance for staffing ratios, which recommend ratios of 1:1 for intensive care babies, 1:2 for high dependency babies and 1:4 for special care babies. No shifts had been covered by a designated supernumerary team leader, which is not in line with BAPM guidance. One nurse on each shift from the neonatal unit was allocated to work on transitional care. The majority of staff on the neonatal unit were qualified in the speciality and every shift had at least two members of staff quality in speciality.

A paediatric nurse covered outpatient clinics that were held in adult outpatient areas, such as ear, nose and throat ENT clinics.

**Medical staffing**

The trust reported their medical staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>29.5</td>
<td>25.6</td>
<td>29.5</td>
<td>29.6</td>
</tr>
</tbody>
</table>

The trust reported that across all three sites, 100.2% of medical posts in services for children and young people were filled as of January 2017. By January 2018 this had declined to 92.3% of posts filled.

At Diana, Princess of Wales Hospital as of January 2018, 86.7% of posts were filled.

**Vacancy rates**

Annual vacancy rates for medical staff in services for children and young people from February 2017 to January 2018 are shown below.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>3.9</td>
<td>29.5</td>
<td>13.2%</td>
</tr>
</tbody>
</table>

The trust had an annual vacancy rate of 10.9% for medical staff in services for children and young people, which was above the trust’s target vacancy rate of 6.3%. The target was not met at Diana, Princess of Wales Hospital.

Please note, while the figures for January 2018 show all three sites meeting the trust’s vacancy target, the annual rate is calculated over the 12 month reporting period.
Turnover rates

Annual turnover rates for medical staff in services for children and young people from February 2017 to January 2018 are shown below.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>3.0</td>
<td>13.3</td>
<td>22.5%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 18.2% for medical staff in services for children and young people, which was higher than the trust's target of 9.4%.

(SOURCE: Routine Provider Information Request (RPIR) P17 Vacancies)

Sickness rates

Sickness rates for medical staff in services for children and young people from January 2017 to December 2017 are shown below by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>114.0</td>
<td>4,905.3</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 3.0% for medical staff in services for children and young people, which was lower than the trust’s target of 4.1%.

Bank and locum staff usage

The trust did not provide the total medical shifts available. Therefore, bank and locum usage as a proportion of total shifts available cannot be calculated.

From February 2017 to January 2018, the trust reported the following shifts for bank and locum staff:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle Grade</td>
<td>15</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

In services for children and young people at Diana, Princess of Wales Hospital, from February 2017 to January 2018, one middle grade medical staff shift was filled by a bank medical staff member. In addition, one middle grade medical staff shift was filled by a locum medical staff member. There were no shifts that were left unfilled to cover staff absence.
The cover for the neonatal unit was not compliant with the British Association for Perinatal Medicine (BAPM) standards, which recommend that there should be a minimum of seven consultants on the on-call rota with a minimum of one consultant with a designated lead interest in neonatology. The service had six consultants that covered the neonatal unit.

Consultant cover was not compliant with the Royal College of Paediatrics and Child Health (RCPCH) *Facing the Future* Standards, which state that a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week. One consultant covered the children’s ward between 9am and 1pm and one consultant covered the neonatal unit between 9am and 5pm. This consultant also covered the children’s ward after 1pm. After 5pm, an on-call consultant was non-resident. This consultant returned to the ward for the ward round and to see new admissions. Service leads told us that they were putting forward a business plan to recruit more medical staff to meet the RCPCH standards.

Two consultant led handovers were held each day and all new admissions were seen within 14 hours of admission by a consultant, in line with the RCPCH standards. There was a daily consultant ward round, this took place seven days a week on the children’s ward but did not take place on a weekend on the neonatal unit.

Service leads told us they had recently recruited new consultants, who were due to start work in June and August 2018.

**Staffing skill mix**

In December 2017, the proportion of consultant staff reported to be working in services for children and young people at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

**Staffing skill mix for the 45 whole time equivalent staff working in services for children and young people at Northern Lincolnshire and Goole NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>19%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>31%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>16%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
Records

We reviewed 17 sets of records. All were clear, accurate and legible. The records were a collaborative document, which all staff used. The names and signatures of everyone that had written in the document were listed on a sheet within the record, this aided with the recognition of signatures. We saw on the children’s ward that the nursing staff wrote in red pen to differentiate between nursing staff and medical staff.

Records were kept securely in every area we visited. The child development centre and specialist nurses used electronic records and paper records. A record of a child’s assessment was stored in the medical records but staff on the ward could not access the child development centre or specialist nurses’ records to see any updated information about the child’s care.

Medicines

Staff used an electronic key system. Each key was registered to a particular staff member and this registered electronically every time a medicine cupboard was accessed, including the controlled drug cupboard. This meant that there was an audit trail as to which member of staff had accessed the cupboard.

On the children’s ward, staff were able to administer some medicines using a patient group direction (PGD). PGD’s can act as a direction to a nurse to supply and/or administer prescription only medicines to patients using their own assessment of patient need. We saw that these had been signed by staff to acknowledge compliance. However, the ones we saw were old documents and the staff member we spoke with was unsure where the most recent ones were.

On the children’s ward, we saw intravenous fluids containing potassium stored with other intravenous fluids. This was against the trust’s Medicines Code policy, which stated that ‘potassium containing solutions must be stored separately from ordinary infusion fluids’. We raised this with the staff at the time of our inspection; when we returned to the ward the next day this had been rectified.

The rooms where medicines were kept did not have their temperature routinely monitored. We noted that the temperature in the room on the neonatal unit was hot. There was therefore a risk that medicines were stored above recommended temperatures.

When children with long term/chronic illnesses were admitted, the ward had the facilities to store individual medicines in lockable cabinets by the child’s bed. Parents completed a competency assessment to enable them to self-administer their child’s medicines.

We saw appropriately completed prescription charts, including a separate gentamycin prescription chart on the neonatal unit.

We saw that controlled drugs (CDs) were checked weekly and CD records were appropriately completed.

We saw completed checklists for checking of medicine fridge temperatures, staff followed an escalation policy to respond to any deviations from the normal temperature. However, the drug fridge in the paediatric assessment unit was not locked and we found it had food in it. We raised this with the staff at the time of our inspection and they removed the food and told us they were waiting for a lock to be fitted.
A paediatric pharmacist visited the wards every day. All pharmacists were trained to be able to work in the paediatric area if needed.

The trust scored 9.1 out of ten for question 36, ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts. This question was asked of parents and carers of children up to 15 years of age.

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q36. Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

**Incidents**

Staff we spoke with told us they were encouraged to report incidents via the electronic reporting system and received feedback about incidents they had reported.

At our last inspection, we found that learning from incidents was not always effectively shared. At this inspection, we found that staff received feedback about incidents and lessons learned at team meetings. The new band seven on the children’s ward had recently introduced ‘lessons of the week’.

We saw evidence in governance meeting minutes that incidents were a standing item for discussion. Patient safety alerts were also discussed at these meetings. We also saw discussion of incidents in team meeting minutes.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events in services for children and young people.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident in services for children and young people which met the reporting criteria set by NHS England from March 2017 to February 2018.

The incident was categorised as a commissioning incident and occurred at Diana, Princess of Wales Hospital in July 2017.

*(Source: Strategic Executive Information System (STEIS))*

We reviewed the incident report for the above serious incident and found there had been a
thorough investigation of the incident and an appropriate action plan was made.

We saw information boards displayed in all areas about the duty of candour and staff we spoke with understood their responsibility to be open and honest with children and families.

**Safety thermometer**

The service did not use a specific paediatric or neonatal safety thermometer.

---

**Is the service effective?**

**Evidence-based care and treatment**

Policies and guidelines were evidence-based and based on national guidance, including National Institute for Health and Care Excellence (NICE) guidance. The neonatal unit used the neonatal network guidance. We reviewed ten guidelines and found them all to be up to date.

Maternity and neonatal services had achieved Baby Friendly Initiative (BFI) level three accreditation. Baby Friendly accreditation is based on evidence-based standards designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways that support optimum health and development.

The neonatal unit had submitted a second audit and action plan for Bliss accreditation. Bliss Baby Charter accreditation is awarded to those units that have embedded a high-quality approach to family centred care following the Bliss Baby Charter principles.

All medical trainees had an audit project to undertake under the supervision of a consultant and the service participated in local and national audits.

**Nutrition and hydration**

A children’s menu was available, providing age appropriate nutrition. However, there were no meals provided on the paediatric assessment unit. Staff we spoke with told us they could order a meal from the kitchen if needed but this was not routine practice and that parents would get something for their child to eat. We spoke to a family that were in the unit and they told us they had bought their child some food.

We saw a ‘you said, we did’ display, which identified that parents and children, had asked for more information about the food provided to help make an informed decision for children with food allergies. The service had responded by designing a new allergy free menu.

Breastfeeding mothers were provided with meals during their child’s stay in hospital. Other parents staying overnight with their children were offered breakfast.

**Pain relief**

Appropriate paediatric pain assessment tools were used, which used verbal and non-verbal cues. We saw completed pain assessment charts. The neonatal unit used a neonatal infant pain scale.

Records showed that appropriate pain relief was prescribed and administered.

Play leaders provided distraction during painful procedures.
There was no dedicated children’s pain team but staff could contact the adult pain management
team for advice if needed.

**Patient outcomes**

Children's services took part in a number of local and national audits, including the National
Paediatric Diabetes Audit and the National Neonatal Audit Programme (NNAP).

Patient outcomes were in line with or better than the national average.

**Paediatric diabetes audit 2015/16**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over
time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare
professional a documented personalised HbA1c target, usually between 48mmol/mol and
58mmol/mol (6.5% and 7.5%)”.

In the 2015/16 diabetes audit, Diana, Princess of Wales Hospital performed similar to or better
than the England average.

The crude proportion of patients receiving all key care processes annually was 57.1%, which
made the hospital a positive outlier. The national aggregate was 35.5%. The hospital’s result for
this metric in the 2014/15 report was 20.0%.

The mean average HbA1c value (adjusted by case-mix) for the hospital was 68.3 mmol/mol,
which was the same as the national aggregate. The hospital’s result in the 2014/15 report was
also within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 66.5, which reflected
clinically significant improvement when compared to the previous year’s median, which was 69.5.

*(Source: National Paediatric Diabetes Audit 2015/16)*

Following our inspection, the trust provided us with the results of the 2016/2017 paediatric
diabetes audit, which showed an improving picture. The median HbA1c was 63, which was
similar to the England average of 64 and showed an improvement on the previous year.

**Emergency readmission rates within two days of discharge**

From September 2016 to August 2016, no specialty at the trust reported six or more
readmissions following elective admission for patients either aged under one year of age, or aged
from one to 17 years old.

The tables below show the percentage of patients (by age group) who were readmitted following
an emergency admission over this period. Only those specialties where six or more readmissions
recorded are shown in the table.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency readmissions within two days of discharge following emergency admission among the under one age group, by treatment specialty (September 2016 to August 2017)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For patients aged under one year old the trust performed better than the England average for emergency readmission rates following an emergency admission to general paediatrics. It should be noted that the number of readmissions at the trust was quite small.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Readmissions (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.2%</td>
<td>2,363</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

For patients aged from one to 17 years of age the trust performed better than the England average for emergency readmission rates following an emergency admission to general paediatrics. Again, it should be noted that the number of readmissions at the trust was quite small.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From October 2016 to September 2017 the trust performed similar to the England averages for the percentages of patients aged from one to 17 years of age who had multiple admissions for asthma and diabetes. The trust performed better than the England average for the percentage of patients in the same age group who had multiple admissions for epilepsy.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 and 1 to 17 years) (October 2016 to September 2017)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Under 1</td>
<td>14.5%</td>
<td>117</td>
</tr>
<tr>
<td>1 to 17</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Diabetes</td>
<td>11.8%</td>
<td>51</td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
National Neonatal Audit Programme

Both of the trust’s sites that provide services for children and young people participated in the 2017 National Neonatal Audit.

Diana, Princess of Wales Hospital’s performance in the four measures in this audit relevant to services for children and young people was as follows:

**Babies <32 weeks gestation who had temperature taken within an hour of admission that was between 36.5ºc and 37.5ºc**

Out of 31 eligible cases identified for inclusion, 58.7% of babies less than 32 weeks gestation had a temperature taken within an hour of admission that was between 36.5ºc and 37.5ºc. This was within the expected range when compared to the national aggregate of 61.0%.

The hospital did not meet the audit’s recommended standard of 90% for this measure.

**Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission**

Out of 237 eligible cases identified for inclusion, 99.3% had a documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission. This was a positive outlier when compared to the national aggregate of 90.5%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

**Babies of very low birthweight or <32 weeks gestation who receive appropriate screening for retinopathy of prematurity**

Out of the 27 eligible cases identified for inclusion, 94.8% of babies of very low birthweight or less than 32 weeks gestation received appropriate screening for retinopathy of prematurity. This was within the expected range compared to the national aggregate of 94.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

**Babies with gestation at birth <30 weeks who had received documented follow-up at two years gestationally corrected age**

Out of the 18 eligible cases identified for inclusion, 61.1% of babies with a gestation at birth of less than 30 weeks received a documented follow-up at two years gestationally corrected age. This was in the middle 50% of results. The national aggregate was 61.2%.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

During our inspection, we asked the service leads about the actions they had taken following the
results of the neonatal audit. They told us that they worked more closely with their obstetric colleagues and they worked closely with the neonatal network. There was better temperature monitoring of babies on the labour ward now. A clinical audit action plan was in place. We saw evidence in clinical governance meeting minutes of discussion around improving the retinopathy of prematurity outcome by the possible purchase of a retinal camera.

**Competent staff**

Staff underwent a two-week trust induction. On the children’s ward, new staff worked for four weeks supernumerary if they were newly qualified, or two weeks if already qualified. Staff completed a six-month preceptorship programme and completed a preceptorship booklet.

The service employed three paediatric nurse practitioners who were based on the medical rota. They covered the ward, assessment unit and clinics.

Four hospital play specialists and two nursery nurses covered the ward and community blood clinics. One worked in the child development centre. The play specialists carried a bleep so that they could be contacted to provide support when needed in the paediatric assessment unit and the outpatients department.

The specialist nurses had started to introduce teaching sessions on the ward. We spoke to the epilepsy nurse specialist who told us she had done some training to ward staff for them to be able to train parents how to use rescue medication.

There were link nurse roles on the ward for each speciality so that the specialist nurses had an identified liaison on the ward.

The children’s community nursing team undertook competencies; staff we spoke with told us they were in the process of updating the competencies and had set up a competency document in order to record staff competencies.

Staff in the paediatric assessment unit we spoke with told us that staff would only work on the unit if they had done the European Paediatric Life Support (EPLS) course. Staff on the neonatal unit that worked regular bank shifts on the children’s ward did the EPLS course.

At our last inspection, we were not assured that staff had received the necessary paediatric life support training. At this inspection, we were told that there was a staff member trained in Advanced Paediatric Life Support (APLS) on every shift on the children’s ward. We requested APLS training data from the trust, however we were not provided with this information for Diana, Princess of Wales hospital.

The neonatal unit ran clinical skills training once a month, which covered situations such as chest drains, intra osseous access, endotracheal tube fixation and umbilical access. Simulations were carried out twice a year. The unit manager told us that they were exploring the possibility of sending staff to work in a level three neonatal unit in order to increase their skills. We saw evidence of staff attendance at simulation sessions and positive

Medical trainees we spoke with reported been well supported by consultants and receiving good educational and clinical supervision.

Consultants all had job plans and appraisals. We looked at five of these and found them to be satisfactory.

Staff had not received any specific training around caring for children and young people with mental health needs.
Staff received training in sepsis management, however data received from the trust showed that there was 53% compliance with sepsis training.

Nurses working on the neonatal unit were able to cannulate, take bloods and do blood gases.

When we spoke with staff on the wards, they told us that they had completed their appraisals. On the neonatal unit, there were two members of staff that had not had an appraisal, due to sickness and maternity leave. Staff told us that appraisals did not run from April to March but were dependent on when the start date was. However, the data provided by the trust showed that staff were not meeting the trust target of 95% for completion of appraisals.

**Appraisal rates**

From April 2017 to January 2018, 64.3% of staff within services for children and young people at the trust had received an appraisal compared to a trust target of 95%. The target was met for only two out of six staff types at trust level. In particular only half of qualified nurses had received an appraisal.

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>10</td>
<td>13</td>
<td>76.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>39</td>
<td>68</td>
<td>57.4%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>18</td>
<td>33</td>
<td>54.5%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84</strong></td>
<td><strong>133</strong></td>
<td><strong>63.2%</strong></td>
<td><strong>95.0%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Safeguarding and looked after children team

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>22</strong></td>
<td><strong>90.9%</strong></td>
<td><strong>95.0%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>
The 95% target was not met across all staff groups at either hospital staff, or for staff in the cross-site safeguarding and looked after children team. At both hospital sites the target was not met for either qualified nursing staff or medical staff.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Following the inspection, we received data broken down by ward, however this still showed that staff were not meeting the trust target for compliance.

<table>
<thead>
<tr>
<th>Ward Description</th>
<th>No</th>
<th>Yes</th>
<th>Grand Total</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>208 DPOW Critical Care Ward Nicu (2450)</td>
<td>9</td>
<td>28</td>
<td>37</td>
<td>76%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>58%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>4</td>
<td>7</td>
<td>25</td>
<td>84%</td>
</tr>
<tr>
<td>208 DPOW Medical Staff Neonatal (3622)</td>
<td>2</td>
<td>2</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>2</td>
<td>2</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>208 DPOW Medical Staff Paediatrics (3617)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>67%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>2</td>
<td>10</td>
<td>12</td>
<td>83%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>3</td>
<td>3</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>208 DPOW New Born Hearing Screening (2452)</td>
<td>3</td>
<td>3</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>2</td>
<td>2</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>1</td>
<td>1</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>208 DPOW Paediatric Nursing Community and Outreach (2457)</td>
<td>17</td>
<td>2</td>
<td>19</td>
<td>11%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>3</td>
<td>3</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>14</td>
<td>2</td>
<td>16</td>
<td>13%</td>
</tr>
<tr>
<td>208 DPOW Paediatric Outpatient Department (2454)</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>75%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>75%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>75%</td>
</tr>
<tr>
<td>208 DPOW Paediatric Play Specialist (2459)</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>60%</td>
</tr>
<tr>
<td>208 DPOW Paediatric Wards (2453)</td>
<td>12</td>
<td>18</td>
<td>30</td>
<td>60%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>67%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>9</td>
<td>12</td>
<td>21</td>
<td>57%</td>
</tr>
</tbody>
</table>

Multidisciplinary working

Staff in the child development centre worked closely with early year’s practitioners, portage and an educational psychologist.

Specialist nurses liaised with the specialist nurses in the adult services to ensure that young people transitioned in to adult services smoothly. The service was developing a clinical nurse coordinator for complex care role and the role was to include the transition process. The diabetic service had a diabetes transitional care document, which was started at 11 years old; the young people then attended a combined adult clinic at 16 years of age. The epilepsy specialist nurse told us that they held transition clinics with adult neurologists four times a year.

We saw evidence in records of good communication between ward staff and the child and adolescent mental health services (CAMHS) team.
Children’s services benefitted from a play team to help support children and their families.

**CQC Children and Young People’s Survey 2016 – Q36**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.6 out of ten for question 23, ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

**Seven-day services**
The community nursing team worked seven days a week from 8am to 8pm.

The diabetic nurse specialists were on call to provide support to the ward when there was a newly diagnosed diabetic.

Children’s services had access to diagnostic services, such as radiology and laboratory services, during a weekend. However, it had been identified on the risk register that children’s services could only access ultrasound services between 8am and 8pm.

**Health Promotion**
We saw health promotion displays throughout the children’s services.

In the adolescent room on the children’s ward there was a poster displayed which gave information on bullying and child sexual exploitation.

In the paediatric assessment unit, we saw a poster advertising a website that patients and parents could access to help them manage their diabetes.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**
Staff we spoke with had a good understanding of Gillick competence when considering consent to treatment for children and young people.

Staff understood the mental capacity act (MCA) and their responsibilities in assessing parent’s capacity to make decisions about their child’s care.

Staff had access to a consent to examination and treatment policy. This was up to date and considered parental responsibility and assessing capacity in children and young people (Gillick and MCA)

**Other CQC Survey Data**

**CQC Children and Young People’s Survey 2016 Data**

The trust performed about the same as other trusts for five of the six questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. For the one remaining question, the trust did not receive a score:

*CQC Children’s Survey questions, effective domain, Northern Lincolnshire and Goole NHS Foundation Trust*
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q21. Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults*</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q54. Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 children**</td>
<td>No Score</td>
<td>-</td>
</tr>
</tbody>
</table>

*0-15 adults = asked of parents and carers of children up to 15 years of age.
**8-11 children = asked of children aged from eight to 11 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

Compassionate care

During the inspection, we observed staff treating children, young people and their families with dignity and respect. They were seen to be friendly and caring.

We spoke to ten children, young people and their families. All that we spoke with told us they were happy with the care provided. They told us that they felt that the whole family was cared for.

Friends and family test (FFT) responses were consistently positive. For example, we saw that 100% of respondents on the neonatal unit and 100% of respondents on the children’s ward would recommend the service. A monthly privacy and dignity audit of 10 families showed that they had achieved 100% satisfaction.

We reviewed eight feedback forms from parents with children seen at the child development centre. All gave positive feedback about the care received.

The neonatal unit had a quiet hour every day, which allowed parents time to spend with their babies uninterrupted by medical or nursing staff.

The neonatal unit used a butterfly sticker to identify those families that had a multiple pregnancy where not all of the babies had survived. This allowed staff and visitors to be aware and sensitive to the needs of those parents.

CQC Children and Young People’s Survey 2016
The trust performed about the same as other trusts for all 10 questions relating to compassionate care in the CQC Children and Young People’s Survey 2016:

CQC Children and Young People’s Survey 2016 questions, compassionate care, Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults*</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q58. Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 children**</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q64. If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 children</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q74. Do you feel that the people looking after you were friendly?</td>
<td>8-15 children</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q75. Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 children</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-7 adults = asked of parents and carers of children up to seven years of age.
**8-15 children = asked of children aged from eight to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Emotional support

Open visiting was allowed for parents on the children’s ward and neonatal unit. This meant that parents could spend as much time with their child as they wanted.

A psychologist saw new diabetic patients within the first three months of diagnosis. They were given support in school and clinic.

Play specialists were available to provide support to children and young people to alleviate their anxieties.

On the children’s ward, there was a link nurse for bereavement and end of life care. A link nurse for sudden infant death worked as part of the safeguarding team.

Spiritual support was available to families at any time.
CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for all five questions relating to emotional support in the CQC Children and Young People’s Survey 2016:

### CQC Children and Young People’s Survey 2016 questions, emotional support, Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults*</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q65. Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 children*</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q67. If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 children</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-7 adults = asked of parents and carers of children up to seven years of age.
**8-15 children = asked of children aged from eight to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

Parents we spoke with told us they felt fully informed and kept up to date on what was happening with their child.

Parents felt involved in their child’s care and told us that they were given information in a form they could understand. Parents told us that they felt that staff respected their decisions in their child’s care.

CQC Children and Young People’s Survey 2016

The trust performed worse than other trusts for two questions, and about the same as other trusts for 18 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. The trust received no score for the one remaining question.

The two questions where the trust scored worse than other trusts both related to poor communication:

- Q12: Did members of staff treating your child communicate with them in a way that your child could understand? The trust scored 6.5 out of 10 for this question.
- Q41. Do you feel that the people looking after your child listened to you? The trust scored 7.7 out of 10 for this question.
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q11. Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults*</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>6.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q13. Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. When you left hospital, did you know what was going to happen next with your child's care?</td>
<td>0-15 adults</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>7.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q59. Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 children*</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q60. When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 children</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q61. Did you feel able to ask staff questions?</td>
<td>8-15 children</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q62. Did the hospital staff answer your questions?</td>
<td>8-15 children</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q63. Were you involved in decisions about your care and treatment?</td>
<td>8-15 children</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q66. If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 children</td>
<td>No Score</td>
<td>-</td>
</tr>
<tr>
<td>Q69. Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>8-15 children</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Age group</td>
<td>Trust score</td>
<td>Comparison to other trusts</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Q70. Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>8-15 children</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q72. When you left hospital, did you know what was going to happen next with your care?</td>
<td>8-15 children</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*0-15 adults = asked of parents and carers of children up to 15 years of age.
**8-15 children = asked of children aged from eight to 15 years of age

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The children’s ward had an adolescent room, which contained a television and a games console. Staff we spoke with told us that the young people did not have access to Wi-Fi, as they could not control what the young people might access. A local school had been involved with the painting of the adolescent room.

A playroom was available for younger children, which contained a range of different games and activities. Bedside televisions were available which were free to watch during the day.

The children’s ward admitted children up to the age of 16 years or 18 years for those young people with complex needs or chronic problems. The service had produced a ‘Guideline on the admission of 16 and 17 year olds’. There was no separate ward area for older children and young people and it was therefore possible that they would be nursed alongside younger children.

The specialist nurses had held a parent’s forum where they had invited parents of children with different conditions to attend. At the forum, they asked the parents what they wanted from the service and where they felt there were gaps in the service provision.

The role of the specialist nurses meant that there was a reduction in the number of admissions to the ward.

The children’s ward and the neonatal unit both had a parent’s room where parents could go to sit and make themselves a drink. On the children’s ward, parents could stay at the child’s bedside and the neonatal unit had four bedrooms available for parents to stay overnight.

There was ongoing work with the commissioners to provide a service that met The National Institute for Health and Care Excellence (NICE) guidance for those children requiring an assessment for a diagnosis of autism. This had been identified as a risk on the risk register as they were not commissioned to provide this service. Staff in the child development centre that we spoke with told us that they provided advice to parents, such as attending playgroups, while they waited for their assessment. The children could also be seen by the speech and language therapists.

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for 14 of the 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016. For the remaining three
questions the trust did not receive a score.

CQC Children and Young People’s Survey 2016 questions, responsive domain, Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>Comparison to other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults*</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q5. Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q55. Was the ward suitable for someone of your age?</td>
<td>12-15 children**</td>
<td>No Score</td>
<td>-</td>
</tr>
<tr>
<td>Q8. Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q37. Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q56. Were there enough things for you to do in the hospital?</td>
<td>8-15 children</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q57. Did you like the hospital food?</td>
<td>8-15 children</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q71. Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 children</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q73. Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 children</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q2. Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>-</td>
</tr>
<tr>
<td>Q3. Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>-</td>
</tr>
</tbody>
</table>

*0-15 adults = asked of parents and carers of children up to 15 years of age.
**12-15 children = asked of children aged from 12 to 15 years of age  
(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Meeting people’s individual needs

The child development centre (CDC) provided a range of services, including assessments and therapeutic interventions for children under five with additional needs. Within the CDC, there was a sensory room, a playroom, an outside play area, a splash pool, a small gym with soft play area, a large gym and specialist therapy rooms.

The children’s ward had a dedicated quiet room for breaking bad news.

Staff we spoke with told us they could access interpreters, either on the telephone or face to face, when needed.

The Accessible Information Standard (AIS) (2017) produced by NHS England, directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. When we spoke with staff, they told us that they did not routinely ask parents or carers about any disability or sensory loss.

There was a range of specialist nurses employed by the service. There were two diabetic nurse specialists, an endocrine nurse specialist, an oncology nurse specialist, a respiratory nurse specialist, a continence nurse specialist, an epilepsy nurse specialist and three neonatal outreach nurses. For children that were seen within many different specialities a monthly multidisciplinary meeting was held, attended by every nurse specialist, so that care could be coordinated. They were in the process of developing a clinical nurse coordinator for complex care role who would take the lead for coordinating this care.

Some children had end of life plans that were planned between the specialist nurses and the hospice. The ward held a copy of these, which we saw contained the child’s resuscitation status and their wishes around end of life care.

Some patients had a ‘passport’, which used a traffic light system to identify information about the child. Green indicated information about their likes and dislikes, amber was information that it was advisable to know about the child or young person and red was information you must know in order to support the child or young person.

The ward had a designated link nurse for bereavement and end of life care. A quiet room was available for parents to spend time with their child after they had died and memory boxes were available which included moulds for hand and foot prints.

The children’s community nursing team promoted early discharge and provided home teaching and support such as wound checks, gastrostomy button changes, checks for babies with bronchiolitis, stoma care and home intravenous antibiotics.

Staff we spoke with on the ward told us they would involve the play staff and discuss with parents the best way to care for a child with learning disabilities. For planned admissions, the child and family could visit the ward prior to admission. We saw a board on the children’s ward, which was a visual board with Makaton signs and pictures; this explained what would happen on a visit to the children’s ward.

Access and flow
The paediatric assessment unit was co-located next to the accident and emergency unit and was open from 10am until 9/9.30pm every day. The average length of stay in the unit was between four and six hours to ensure that children and young people were medically fit for discharge or needed admission to the children’s ward. There was a junior doctor and a middle grade doctor allocated to the children’s observation unit, this meant that children and young people did not have to wait to be seen whilst the doctor was seeing other patients on the children’s ward.

During our last inspection, we found that out of hours, the paediatric assessment unit was used by accident and emergency as an additional bed space, which meant that at times the assessment unit was not able to open in the morning. At this inspection, staff we spoke with told us that this had not happened in the last year and a half.

Parents we spoke with in the outpatients department told us that they were not kept waiting and they felt the department ran efficiently.

The NHS Constitution (2010) gives patients the right to access services within maximum waiting times. The standard is that at least 92% of people should spend less than 18 weeks waiting for treatment. Data provided by the trust showed that paediatrics were consistently meeting this standard between November 2017 and April 2018.

**Neonatal Critical Care Bed Occupancy**

From February 2017 to January 2018, the trust’s neonatal bed occupancy rate fluctuated from 45.5% (April 2017) to 92.0% in June 2017.

The trust’s neonatal bed occupancy rate was higher than the England average in eight of these 12 months. From August 2017 to January 2018, there was a deterioration in bed occupancy. In February the trust’s bed occupancy was 77.3% compared to the England average of 69.0%.

**Neonatal bed occupancy rate from March 2017 to February 2018 at Northern Lincolnshire and Goole NHS Foundation Trust**

Note that data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

*(Source: NHS England)*

**Learning from complaints and concerns**

From 7 February 2017 to 7 February 2018, there were no complaints related to children’s services at Diana, Princess of Wales Hospital.
We saw information displayed in most areas as to how to make a complaint. However, we did not see any information in the paediatric assessment unit.

Staff we spoke with told us they would try to resolve any concerns at ward/department level. If the parents still wanted to make a formal complaint then they gave them information on how to do so.

Parents we spoke with told us they had not considered making a complaint but they would know how to. Parents were given an admission/discharge information leaflet on the children’s ward and the neonatal unit, which contained information about how to raise concerns.

Is the service well-led?

Leadership

The children’s service formed part of the women’s and children’s group. The leadership team consisted of an associate chief operating officer, a clinical lead for each site and an interim chief nurse. The women’s and children’s group had a divisional clinical director and a divisional general manager.

There had previously been a lack of senior leadership at Diana, Princess of Wales Hospital, but at the time of our inspection, there was a new ward manager and a new matron. Staff we spoke with talked positively about the leaders and felt they were making improvements. Leaders were described as approachable, visible and willing to listen.

Since our last inspection, a lead anaesthetist for paediatric surgery had been identified. However, there was still no identified paediatric lead surgeon, although the leadership team attended surgical meetings and had made a request for a named lead.

New band six nurses on the children’s ward were due to attend a leadership study day.

Vision and strategy

The service had a clear, documented strategy. However, it had only recently been shared with staff and so staff we spoke with were unable to tell us about the contents of the strategy. Service leads told us that although the strategy had been developed in 2017, with input from staff members, there had been a delay releasing the document due to work pressures.

Staff we spoke with were able to tell us about the wider vision for the children’s services.

The children’s ward had a philosophy of care displayed which included respect, approachable, individual, nurturing, families, open and honest, responsive, encourage, suitably qualified staff and team. This philosophy of care was aligned to the trust values.

Culture

Staff we spoke with told us they worked well as part of a team. There was a good relationship between the medical and nursing staff.

At our last inspection, staff morale had been affected by staff shortages and demands on the service. At this inspection, staff we spoke with told us that morale had improved and they felt that it was now good.
Staff we spoke with talked positively about the service they provided to children, young people and their families.

When we spoke with the service leads, they told us that they felt the culture had changed. There was more support from the executive team, there was good teamwork and staff were happier coming to work.

**Governance**

There was a clear and effective governance structure in place. Monthly paediatric clinical governance meetings took place on alternate hospital sites. A risk and governance facilitator for the women and children’s group supported the team with the governance meetings. These clinical governance meetings ensured that information was fed up to board level and back down to ward level.

A weekly senior leadership meeting was held which ensured information from the monthly governance meeting was fed in to the monthly divisional performance meeting.

A governance action log was produced from the governance meetings. We reviewed meeting minutes and saw that audits were regularly discussed.

We saw that the board received an annual safeguarding report and this had last been in August 2017.

**Management of risk, issues and performance**

There was a comprehensive risk register in place for the service, which was reviewed every month at the clinical governance meetings. This identified risks, mitigation, review dates and progress.

At our last inspection, we found that identified risks were not always appropriately recorded or monitored. At this inspection, we found that all risks had been appropriately recorded but some had been on the register for a long period. When we discussed this with the service leads, they told us that these were longstanding risks that had been mitigated as far as possible.

Since our last inspection, a lead anaesthetist had been identified for children’s surgery.

**Information management**

A divisional performance report was produced monthly, which allowed leaders to monitor performance and quality. The performance report presented key quality performance figures, such as number of never events, number of infections, staffing and waiting times.

Staff had access to clinical policies and guidelines on the trust intranet.

**Engagement**

Staff we spoke with told us they received emails from the chief executive and the trust produced a staff magazine, which kept them up to date with what was happening in the trust.

The chief executive held open forums to find out staff views, staff we spoke with told us they felt they were listened to and action had been taken when they had raised an issue about parking.

The children’s ward used child friendly ‘tops and pants’ cards to get feedback from patients. All of the children’s services participated in the friends and family test. Results were consistently positive.
We saw evidence displayed of ‘you said, we did’ For example, on the neonatal unit parents and families wanted more flexible visiting times and the unit had introduced open visiting for families.

The neonatal unit advised families about a Yorkshire and Humber Neonatal Network electronic application where they could leave feedback about the service.

**Learning, continuous improvement and innovation**

Children’s services had made improvements since the last inspection. There had also been some changes made following a recent clinical commissioning group (CCG) visit and neonatal peer review. Service leads were aware of further improvements that were needed.

The service had recognised the benefit of the advanced nurse practitioner role in providing support to staff.

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**End of life care**

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**Facts and data about this service**

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

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

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

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

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

(Source: Routine Provider Information Request (RPIR) AC1 – Acute Context / Hospital Episode Statistics)

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**Is the service safe?**

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**Mandatory training**

**Overall mandatory training rates**

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses February 2017 to January 2018 for medical and dental staff and nursing staff is shown below:

Trust level Medical and dental staff
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Although the trust only hit the target in three of the ten courses, there is only one medical staff eligible for the training so the completion rates are either 100% or 0%.

Trust level nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENT Level 1</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>10</td>
<td>11</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>8</td>
<td>11</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust achieved the target in four of the ten courses and has completion rates above 80% for five of the remaining six courses.
A mandatory training programme for end of life care was provided by the hospital end of life care team, for registered nurses and healthcare assistants. This training programme was delivered as a study day every three years, with different content for registered nursing staff and healthcare staff.

The study day included details about the trust’s end of life strategy, the five priorities of care for the dying person, documentation, including assessments, mental capacity, nutrition and hydration, advanced care planning, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), fast tracking, symptom management and trust processes. The end of life clinical co-ordinator facilitated and monitored compliance rates.

The trust target for training was 85%. From the meeting minutes, April 2018, for the trust’s end of life strategy group, the nurse training compliance rate for pain and symptom control was 75%, care planning compliance was 73% and syringe driver training was 66%.

The training programme has been adapted now to include communications skills. There were plans to extend the training to include patients identified with dementia, a learning disability or autism.

The end of life study day was available for medical staff; however, this was not mandatory at the time of inspection.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for mandatory courses February 2017 to January 2018 for medical and dental staff and nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust achieved 100% completion in each of the safeguarding modules that the medical staff member was eligible for.

Trust level nursing staff
The trust achieved the target in only one of the three safeguarding modules the nursing staff was eligible for. The other two modules had completion rates of 82%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff were aware of safeguarding and knew how to raise any concerns, following trust procedures. Contact details for the trust’s safeguarding lead were available in all wards. Information and any learning about safeguarding incidents was shared with staff in meetings and email communications.

Cleanliness, infection control and hygiene

We saw that ward areas where end of life patients were being cared for were visibly clean.

Adequate handwashing facilities and gel were available, with clear handwashing signs displayed.

Staff were observed using personal protective equipment, including aprons and gloves, to minimise the risk of infection and were ‘bare below the elbow’ in accord with trust infection prevention and control guidelines. Infection control was included in mandatory training. We saw notices on wards promoting awareness of world hand hygiene week at the time of inspection.

Personal protective equipment was available for use in the mortuary and the mortuary environment appeared visibly clean and was free from clutter. The mortuary had designated storage areas for bodies with known infections, either from the wards or in the community. Porters were aware when transporting a deceased patient as body bags were used to easily identify them.

A mortuary cleaning and disinfection guidance document identified different cleaning duties to be completed on a daily, weekly monthly or quarterly frequency. We reviewed cleaning schedules provided at the time of inspection and saw these had been completed, signed and dated appropriately.

Environment and equipment

A viewing room was available for bereaved families to spend time with their deceased relative. The room was sensitively decorated, and had sufficient chairs for families to sit in comfortably.

The mortuary had capacity for 60 deceased persons, including two fridge cabinets that could accommodate three bariatric persons each. A freezer cabinet was also available for long terms storage of deceased persons awaiting the coroner’s approval for the body to be released.

A separate room and cabinet were also available for storage of bodies prior to post mortem. All cabinets were clearly labelled to check the identity of the deceased, with a notice to remind staff to check these details matched with the deceased person contained within each cabinet.
Service level agreements were in place with the manufacturer for the service and maintenance of the fridges and freezers, with services carried out annually. Fridge temperatures were displayed continuously and these were able to be viewed and monitored continuously.

A temperature alarm system on the fridges triggered alerts to the trust switchboard and the hospital’s facilities department. In the event of any breakdown, staff told us the cabinets could maintain their temperature for up to four hours, whilst following up emergency arrangements for repair. Mortuary staff told us there had been no issues with breakdown of this equipment and no incidents reported since its installation two years ago.

The mortuary’s post mortem room had two tables and a range of specialist equipment for carrying out post mortems.

Syringe drivers for patients receiving medicines in their end of life care were stored in a central equipment library. These were requested by staff for individual patient’s use when this was required. Syringe drivers were tamper proof to prevent unauthorised use. Spot checks of this equipment confirmed maintenance checks had been completed during the last 12 months.

Assessing and responding to patient risk

Patients who were in last days of life were assessed by medical and nursing staff, following guidance set out in the trust’s last days of life document. Nursing staff undertook intentional rounding checks to monitor patients’ basic care and comfort needs. This included checks of pain control, nutrition and hydration, psychological needs, spiritual needs and the wishes of the patient and their families and carers. This monitoring allowed staff to note any changes in the patient’s condition and respond accordingly.

Ward staff used the national early warning score (NEWS) tool to identify patients whose condition was deteriorating. When nurses identified patients who were continuing to deteriorate, they would refer the patient to medical staff for review and assessment for the last days of life documentation. Staff told us they also took into account change in the patient’s behaviour or communication in their continuing assessments. The frequency of NEWS monitoring was reduced or stopped for patients who were identified as in the last days of life, in response to the patient’s declining condition.

The specialist palliative care nurses and the palliative consultant told us that they reviewed patients, in the last days of care daily, during the week. The consultant told us that if concerned about a patient, they would contact the ward at the weekend also.

Nurse staffing

Overall staffing rates

The trust reported their staffing numbers below for January 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>5</td>
<td>4.22</td>
</tr>
<tr>
<td>Trust wide</td>
<td>6.47</td>
<td>7.41</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)
Vacancy rates
From February 2017 and January 2018, the trust reported a vacancy rate of 7% in end of life care. This was worse than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The end of life clinical practice educator at Diana Princess of Wales (DPOW) hospital had left the trust in the week prior to our onsite inspection. The end of life clinical co-ordinator, based at Scunthorpe General Hospital (SGH) was providing cover, on a temporary basis, for both hospitals at the time of inspection.

Turnover rates
From February 2017 to January 2018, the trust reported a turnover rate of 12% in end of life care. This is worse than the trust turnover target of 9.4%.

- Diana Princess of Wales Hospital: 0%
- Scunthorpe General Hospital: 29%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From January 2017 to December 2017, the trust reported a sickness rate of 2% in end of life care at Scunthorpe General Hospital. This was better than the trust target sickness rate of 4.1%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage
The trust did not report any bank or agency usage for end of life care.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing
The trust has reported their staffing numbers below for January 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>1</td>
<td>0.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates
From February 2017 and January 2018, Scunthorpe General Hospital reported a vacancy rate of 20% in end of life care. This was worse than the trust target of 6.28%. The figure is high due to the small number of WTE expected in end of life care.
One consultant in palliative care was employed at the trust, providing cover for both the acute hospitals and the community services. There were no direct cover arrangements for the consultant in case of any leave or absence, although some telephone support was available from the local hospice for urgent needs out of working hours.

Commissioning Guidance for Specialist Palliative Care (2012) recommends the minimum requirement for a population of 250,000 people is two whole time equivalent palliative care consultants, or one per 250 bed hospital. The lack of consultant cover in line with this guidance had been identified at the last inspection. The end of life strategy group had also identified this gap; however there had been no progress in fulfilling the role.

**Turnover rates**

From February 2017 to January 2018, the trust reported a turnover rate of 0% in end of life care.

**Sickness rates**

The trust has not provided any data for sickness for medical staff in end of life care.

**Bank and locum staff usage**

The trust did not report any bank or locum usage for end of life care.

**Records**

Records for patients in last days of life were held on wards in lockable trolleys, which were stored near the nurses’ stations when not in use.

The trust electronic board system on each ward displayed a discreet blue symbol to show when patients were in last days of life. The in-reach palliative care team told us they did not have access to the trust system. However, the end of life clinical practice educator would inform them of any patients who needed to be seen. Since this role was currently vacant, the end of life clinical coordinator based at SGH had access to the system and was providing some cover for this temporarily.

The trust had continued to implement the care in the last days of life document since the last inspection and we saw this was in place and being followed appropriately by staff on the wards where we visited. This document was in two parts. Part one included patient and family details, initial assessments and guidance for the management of symptoms. Part two contained further details of the individual patient’s care plan.

We also reviewed the care in the last days of life document in four patient records. We saw in general these were mostly well completed, including details of discussions with patients and their families or carers; prescribing for anticipatory medicines; and reviews of patient’s care and comfort needs. Some aspects, including medical assessment for commencing care in the last days of life, were not always fully completed. Medical notes continued to be used alongside the care in the last days of life document and these were completed appropriately.
Medicines

The trust had policies and guidance in place for the prescription of anticipatory medicines and the use of syringe drivers for patients receiving end of life care. This included standard forms for the prescription and administration of controlled medicines.

We found the anticipatory drug prescribing for end of life care policy contained in the end of life resource folders on wards was out of date at the time of inspection, being due for review in December 2017. However, this had been updated and was available on the trust intranet. This meant staff might not be using the most up to date guidance.

Anticipatory medicines were ordered and stored in the hospital, securely, until the patient was discharged. These are medicines that are prepared and available for when needed in the near future. The patient took home the medicines when they were discharged, however, the G.P. needed to prescribe these medicines again before community nurses could administer them. This meant there was a risk of delay in the medicines being administered. The end of life steering group had identified this as an issue and was making changes to the process, so that the medicines would be prescribed prior to discharge and there would be no delay in treatment.

We reviewed four records for prescription and administration of anticipatory medicines and found that all medicines had been prescribed appropriately.

Doctors we spoke with told us that they would contact the palliative care team for advice and guidance regarding medicines if needed.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events within end of life care.

Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from March 2017 to February 2018.

Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

The trust did not provide any evidence of any incidents coded as end of life. We did not hear any other details of systems the service used to identify end of life incidents.

The trust had systems and processes in place for reporting incidents. Staff could access the reporting system via the trust’s intranet and were able to demonstrate this. Staff described the types of incidents that would be reported and were confident in the use of the system; however, they said they did not receive feedback or shared learning from this.
Meeting minutes for the trusts end of life strategy group included details of a patient who was discharged with a possibility that the patient may die during the journey; the patient died in the ambulance. There was no policy for patients dying in transit: the patient was returned to the hospital. The incident was not reported as an incident on the trusts system. However, this led to a review and development of a trust policy for transfer of patients who may be at risk of dying in transit.

Staff we spoke with understood the term and principles of duty of candour and where this should be applied. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person. We requested details of any duty of candour for end of life care at the time of inspection, but this was not provided.

Is the service effective?

Evidence-based care and treatment

Trust policies for end of life care followed national guidance, such as the National Institute for Health and Care Excellence (NICE) NG31: Care of dying adults in the last days of life and Ambitions for palliative and end of life care: a national framework for local action 2015-2020.

The latest version of the trust’s procedure for the use of the McKinley T34 syringe driver in palliative care was in place to ensure correct use of syringe drivers.

We observed staff in different ward areas providing treatment and care for end of life patients, in accordance with this guidance. This guidance was also evidenced in the different records we reviewed.

Every ward we visited had a resource folder for end of life care, located near to the nurses’ station. This contained various information and guidance documents, including the end of life care in the last days of life documentation; contact details for the specialist palliative care team based at DPOW and the trust’s end of life team based at Scunthorpe; and meeting minutes for the end of life care link nurse meetings. The meeting minutes showed a range of topical issues were discussed, such as fast track funding for rapid discharge and advanced care planning.

A range of mortuary policies were in place, covering the relevant activities for the service. The policies were in date at the time of inspection.

Nutrition and hydration

Assessment of nutrition and hydration was an integral part of the individual plan of care for patients at the end of life. Nursing staff told us they aimed to support dying patients to eat and drink, according to individual patients’ choice and ability. Depending on the condition of the patient, oral diet and fluids could be taken. Fluids could also be administered intravenously, if a cannula was in situ, or subcutaneously (under the skin).

The care in the last days of life document encouraged relatives to assist patients feeding if they wished and identified where multidisciplinary best interests decisions on nutrition and hydration had been made.

Pain relief
Staff followed the trust’s care in the last days of life document for assessing and managing patients’ symptoms, including their levels of pain. This document set out clear pathways of care for administering the required pain medicines in response to patients’ symptoms.

We saw in four prescription records we reviewed that anticipatory medicines had been prescribed following this guidance and was reviewed appropriately.

Anticipatory medicines included analgesia that remained with the patient if discharged from the hospital.

The trust policy anticipatory drug prescribing for end of life care was out of date at the time of inspection, this having been due for review in December 2017.

Leaflets given to patients included “opioids in palliative care”.

**Patient outcomes**

**End of life care Audit: Dying in Hospital**

The trust participated in the End of life care Audit: Dying in Hospital 2016 and scored marginally worse than the England average for one of the six clinical key indicators, they scored worse than the England average for three indicators, the same for one and better than the England average for one.

For proportion of patients for whom there was documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days, the trust scored 8291% compared to the England average of 8393.4%.

For proportion of patients for whom there was documented evidence within the last episode of care that health professional recognition that the patients would probably die in the coming hours or days had been discussed with a nominated person important to the patient, the trust scored 93.479% which is the same as the England average. compared to the England average of 94.6%.

The trust did score better than the England average for the proportion of patients for whom there was documented evidence in the last 24 hours of life of a holistic assessment of the patient’s needs regarding an individual plan of care, where they scored 839.7% compared to 7663% England average

Overall the trust scored lower worse than the England average for three of the five clinical indicators.

The trust answered yes to seven of the eight organisational indicators, answering only no to “Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?”

(Source: Royal College of Physicians)

Audits of the care in the last days of life documentation were carried out in November 2016 and December 2017. The first audit results provided limited assurance, however; the re-audit provided moderate assurance. There were improvements in eight standards that were comparable to the National End of Life Care Audit – dying in hospital.

Ward staff had access to an electronic recording system for completing the ‘deceased patients’ end of life audit tool’.

**Competent staff**
Appraisal rates

From April 2017 to January 2018, 71% of qualified nursing and health visiting staff within end of life care at the trust had received an appraisal compared to a trust target of 95%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Following the inspection, information provided by the trust showed that the appraisal rate for the specialist palliative care team and for the end of life clinical co-ordinator had improved and was 100%.

The end of life team delivered a range of educational programmes to nursing and medical staff of different grades who were involved in the care of patients in the last days of their life across the hospital.

End of life training, either face to face or e-learning was mandatory for all nursing staff; however, this was optional for medical staff. The palliative care nurses were involved in the delivery of training, including facilitating competency framework requirements for syringe drivers.

Since the last inspection, link nurses for end of life care had been introduced on all wards. Many of the wards had one representative, although some wards included a registered nurse and a health care assistant. We found that staff on the wards were mostly aware of their link nurse. Link nurses had particularly supported staff to implement the trust’s care in the last days of life document.

End of life link nurses were supported in their role by the end of life team and attended meetings every three months to discuss subjects relevant to this area of work. Meeting minutes showed the range of discussions that had taken place, including advanced care planning and facilitating fast track discharges for end of life patients.

Junior doctors reported positive experiences of local end of life training, including training for completion of death certificates, end of life and anticipatory medicines and a regional day on ‘difficult conversations’. The end of life coordinator also told us that training sessions had been arranged, however; these had not been well attended, mainly due to other pressures in the trust.

The palliative care consultant delivered a session on end of life at induction days for junior doctors.

Multidisciplinary working

The service worked well with a variety of different staff, including hospices, community nursing teams and medical staff from different inpatient and outpatient areas.

We saw there was good multidisciplinary working between different services. Medical and nursing staff could refer patients who were on the last days of life document y to the Macmillan palliative care team, based in the hospital. Doctors we spoke with discussed symptom management with the team and were supported by them.

The Haven team facilitated rapid discharge for end of life patients when this was indicated, liaising with specialist palliative care community nursing teams regarding individual patients’ care and support needs. This team assisted in providing a seamless transfer of care between the hospital and community services.

The bereavement officer, mortuary staff and porters worked closely with each other and with staff on different wards, to support care for end of life patients and their families. The chaplaincy team worked well to provide services across the trust’s hospitals and we saw that information about these services was communicated well.
A multidisciplinary meeting was held once a week, at a local hospice that involved hospital and community staff, where patients were discussed. The palliative care course, that acute hospital nurses attended, was held at the local hospice and well attended.

All documentation was kept together so that all health professionals completed the same paper records for patients. There was currently no electronic palliative care co-ordination system; although the rapid discharge team completed an electronic system that was accessed by the community end of life team and G.P’s.

Communication and joint working had commenced with the local council regarding shared end of life training for health and social care staff within the local area.

Through the end of life multi-agency strategy group, the end of life team worked with Northern Lincolnshire and Goole NHS Foundation Trust staff, as well as a variety of other organisations relating to end of life care. Some of these organisations included local hospices, regional clinical networks team representatives and clinical commissioning groups continuing care services.

### Seven-day services

The NHS seven day clinical standards (2017), standard eight, includes that all patients on an end of life pathway must be seen daily by a consultant. NICE guidance (quality statement 10: 2018) states that specialist palliative care and advice should be available at any time of day and night for people approaching the end of life.

There was no end of life clinical practice educator at DPoW due to a current vacancy. At the time of inspection, some cover for this role was temporarily being provided by the end of life clinical coordinator based at Scunthorpe hospital. Staff we spoke with were unsure regarding the impact this current vacancy may have on the timely provision of care for patients receiving end of life care. However, staff were aware of the potential issues and were working together to ensure continuity of care was provided.

Specialist Palliative Care Services provided in North East Lincolnshire were provided by an external provider, commissioned by the local clinical commissioning group

The Macmillan specialist palliative care team based at DPoW were available Monday to Friday from 8am to 5pm. The end of life clinical co-ordinator based at Scunthorpe was available from 9am to 5pm, Monday to Friday.

Out of hours advice and support was accessible by phone, provided by the local hospice.

The mortuary was open during week days from 9am to 4.30pm with an on-call system to cover evenings, night and weekends. An appointment system was in place for viewing of patients by those close to them.

The bereavement office was open during office hours with an appointment system for the collection of the death certificate and patient belongings, although some preferred to attend the ward.

A chaplain was based at DPoW, with support from the wider chaplaincy team for an on-call rota. There was contact with other faith leaders, as needed and a Sunday service was provided, with support from volunteers. Chaplains also supported funerals for patients without financial provision by attending the crematorium ceremony on the nominated day if needed.
The Haven team was available at DPoW from Monday to Saturday between the hours of 8am and 4pm. Staff told us they could usually arrange for rapid discharge for patients on six days out of seven, with the only limitation for this being dependent on a funding decision. Funding decisions were not available on a seven day basis. However, once this was in place, any requests for community equipment could be arranged for the next working day.

Health promotion

The care in the last days of life document identified the overall care needs of patients, including physical comfort, nutrition and hydration needs. Patients’ psychological and spiritual needs were also assessed as part of this care plan, supported by information from patients and their families about any individual preferences patients may have.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust did not provide any information about completion rates for MCA or DOLs training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff asked patients for their consent before carrying out any treatment and personal care activities

Patients who had a do not attempt cardiopulmonary resuscitation (DNACPR) in place were identified on the trust’s electronic display board by a small red rose symbol.

We found that mental capacity act (MCA) assessments were inconsistently completed, either in medical records or as part of the trust’s DNACPR record. In four of eight DNACPR records we reviewed there was no record of patients’ mental capacity having been assessed and there was variable completion of the DNACPR document overall.

Documentation of discussions with the patient’s family and identification of any best interests decisions were not always clear.

Senior leaders acknowledged there were issues regarding the DNACPR document and mental capacity assessment and had identified this as a priority area to develop.

DNACPR records were placed at the front of patients’ case notes to be easily available for relevant staff to view. Two out of eight forms did not identify if a patient had been involved in the discussion three recorded the patient was unwell or confused and one recorded the patient lacked capacity. Three out of eight forms reviewed did not include that there was relative or next of kin involvement in the discussion which was not in line with the trust policy. Three of the eight forms had not been approved by a consultant.

Is the service caring?

Compassionate care

We observed all grades of staff interacting with patients on wards where end of life care was provided. Although not all these interactions involved end of life care patients however, staff consistently displayed a friendly, caring, supportive, and compassionate approach.
Staff respected the dignity of patients and those who were close to them. They were aware of patients’ care needs and communicated in an appropriate and professional manner.

Feedback from patients and their carers confirmed that staff treated patients well and patients felt they were being looked after well.

During the inspection, a patient’s relatives told us that staff had treated their loved one ‘as an individual person’. They commented on the high standards of care for patients in last days of life, saying staff were ‘amazing people who went above and beyond’ when caring for their relative. Patients were cared for in side rooms whenever possible where those close to them could visit outside of routine visiting hours. Wards provided reclining chairs and beds or mats for families to be able to stay close to their relatives. We heard that on occasions, a lack of available side rooms could impact patients’ privacy and dignity, however staff were aware of this and worked hard to provide for patients as they best could if patients had to be cared for in ward bays at end of life.

When deceased patients were transported to the mortuary, a nurse always escorted the patient and porter. Porters described how they sensitively managed the transfer of patients from ward areas, demonstrating their understanding and respect for the privacy and dignity of the deceased and other patients when carrying out such transfers.

The bereavement officer had recently introduced a questionnaire, provided to families to gain feedback about the service. We did not review any feedback from this, however we saw there were a number of thank you cards displayed in the office.

**Emotional support**

All staff introduced themselves and communicated sensitively with patients and those close to them.

Patients, and those close to them, were encouraged to ask questions and were given time to ensure they understood what was being said to them.

We observed staff providing emotional support to patients and those close to them. Leaflets provided from the bereavement office included signposting to local and national support services. Amongst these were Macmillan support line, survivors of bereavement by suicide and the bereavement advice centre.

A specialist mental health nurse was available for urgent needs and a dementia specialist nurse were available for additional support when this was required. A mental health liaison team was provided by an external service to support the mental health needs of patients. We were told this service would usually respond with advice or to assess patients on the same day.

We spoke with a recently bereaved family who praised the support they had received during their relative’s care. They said nurses were always available and staff responded quickly in a sensitive way when needed. They told us staff gave them ‘an extra five minutes of their time, when they didn’t have to or need to do so’.

Patients and those close to them felt they had been provided with sufficient information by staff when they needed this and they were able to ask questions at any time. They told us the patient’s plan of care was shared with relatives and reviewed regularly.

**Understanding and involvement of patients and those close to them**

Ward medical and nursing staff were responsible for related discussions with patients and their families, regarding end of life care. Medical staff involved families in discussions about care plans
for patients who were deteriorating, with support available from end of life link nurses on each ward.

Additional support was provided by a palliative care in-reach service five day per week from an external provider and the trust’s specialist palliative care team based at Scunthorpe hospital, with cover from Macmillan team at weekends.

Records we reviewed showed that discussions had taken place with patients and those close to them.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust did not have a dedicated palliative care ward. Patients who required end of life care were nursed on general wards throughout the hospital.

Specialist Palliative Care Services provided in North East Lincolnshire were provided by Care Plus Group, commissioned by the local Clinical Commissioning Group. This service was available at the hospital from Monday to Friday, between 9 am and 5.00 pm. Specialist nurses from this service provided a hospital in-reach team, with two or three staff available each week day, dependent on varying shifts. This team provided support to different health professionals and visited patients who were identified with palliative care or end of life care needs. The haven team was available on Saturday to support rapid discharge of patients. Outside of this was telephone advice service only for out of hours and at weekends, provided by Care Plus group.

In the week prior to inspection, the end of life co-ordinator based at Diana Princess of Wales Hospital had vacated this post. Staff from the in-reach team told us the co-ordinator would usually assist in identifying any ward patients who needed to be seen, but due to this vacancy, this was not currently possible. The palliative care team were continuing to work with ward staff to ensure patients continued to be identified and received their care when this was needed. The end of life co-ordinator, based at Scunthorpe General Hospital, was providing some cover for this on a temporary basis.

**Meeting people’s individual needs**

Ward staff told us caring for patients who were in last days of life was a priority and wherever possible they ensured patients were nursed in side rooms during this time. Information received from the trust showed that between April 2017 and March 2018, 162 patients (92%) were accommodated in side rooms. Staff spoke passionately about the importance of this in providing care and we saw that every effort was made to ensure that patients’ individual needs were met. However, staff on various wards frequently commented that the lack of available side rooms could limit this on occasions.

Open visiting was provided for families of relatives receiving end of life care, with suitable reclining chairs and mats available for families to stay close to their relatives during this time. Quiet family rooms were available in the different ward areas we visited, providing drink making facilities and comfortable chairs.

The trust electronic board system on each ward displayed a discreet blue symbol to show when patients were in the last days of their life. This helped staff to be aware of the need for additional sensitivity and compassion when caring for patients and their families.
Other symbols were used to identify any individual patient needs, such as dementia or a learning difficulty. These were displayed on the trust’s electronic boards and indicated in patients’ care plans.

Patients had an individualised care plan for their care in the last days of life which included a diary section for relatives to complete. Relatives used this to document any comments, observations or changes in their relative’s condition. This helped ensure all care needs were being met and communication was maintained between ward staff and patient’s relatives.

Documentation for advanced care planning had been introduced during the last 12 months, however we saw limited used of this document in practice and staff told us this was still in development.

There was a trust wide interpreter and translation service; however, staff told us they usually would access other staff members in the trust if this support was required. Patients with hearing impairments could access specialist sign language interpreters if this was needed. Staff also told us they used pictorial symbols to assist in communication for patients when patients had more limited understanding.

There was a range of patient information leaflets on the wards, including for end of life support for those close to patients. The leaflets we saw were available only in English and alternative formats such as ‘easy read’, large font, or Braille were not provided.

The trust’s chaplaincy service provided spiritual, religious and pastoral care and support to staff, patients, their relatives and friends. A chaplaincy team provided multi-faith support to patients and carers, with a chaplain on site each day during normal office hours and an on-call service when this was requested. Chaplains attended multi-faith forums and could access support for a range of faiths. There was a chapel, prayer room and ablution room at the hospital.

Staff in the mortuary had contact with various individual leaders and community groups representing different faiths and were able to provide an understanding of different cultural and religious protocols. The trust’s last offices policy provided guidance for staff regarding a wide range of faiths, as well as instructions about any pacemaker or heart device. Consent for any organ donation was sought whilst the patient was still alive by medical staff and mortuary staff would check this against the organ donor register following an individual patient death.

The mortuary had a dedicated entrance from the outside, with designated accessible parking available nearby, for relatives who wished to arrange a viewing. The trust provided a “help for the bereaved” booklet, providing a range of related information for bereaved relatives.

Bariatric equipment was available in the mortuary including a larger storage area and trolleys. Porters told us that they could also transfer on the patient’s bed through the hospital, with an appropriate cover used specifically for this purpose.

Access and flow

Nursing and medical staff could directly refer patients by phone call to the in-reach palliative care service.

Medical and nursing staff had access to advice and support from the hospital based specialist palliative care community nursing service during working hours in case of further need. Staff from this service reviewed and supported individual patients and staff as required, with support additionally available from the trust’s end of life clinical co-ordinator, based at Scunthorpe hospital. An out of hours telephone advice service was also available at weekends and night, provided by
the local hospice and community Macmillan team, who worked closely with the trust’s end of life team.

In addition to the hospital discharge liaison team, the hospital had a service level agreement with an external provider to support palliative care and end of life patients when they were discharged. The haven team based at Diana Princess of Wales Hospital provided this targeted support for end of life patients.

End of life patients are those that are likely to die within the next 12 months. We found that patients were referred to the palliative care team, following referral from a consultant to be placed on the last days of life documentation when death was imminent.

The haven team facilitated rapid discharges for patients from hospital to their preferred place of care, which could be home, care home, or the local hospice. This team was based in the hospital’s operations room, allowing direct communications with other involved services, such as ambulance services and community palliative care services, when co-ordinating these arrangements.

Information provided by the trust showed that from April 2017 to March 2018 there were 436 patients whose place of death was outside of an acute hospital. Of these patients, 72 (16%) had a care in the last days of care document in place. There were 354 patients (81%) who had a preferred place of death recorded. There were 322 patients (74%) who had anticipatory medicines prescribed and 368 patients (84%) who had a DNACPR form in place.

Information provided by the trust in the mortality and end of life care plan report showed that 43% of patients whose preferred place of death was hospital achieved this at DPoW.

Staff told us most patients could be discharged on the same or next day following their referral, once funding approval was in place. This included on Saturdays, but did not include Sundays, due to accessing funding approvals. We requested further details of rapid discharge audits from the trust at the time of inspection, however this was not provided.

**Learning from complaints and concerns**

**Summary of complaints**

From February 2017 to February 2018 there was one complaint about end of life care. The trust took 215 calendar days to investigate and close the complaint, this is not in line with their complaints policy, which states complaints should be completed in 30-45 working days or 60 working days for complex complaints.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We saw that information about providing feedback to the trust was available in all wards we visited.

**Compliments**

The data provided by the trust included no compliments for this core service; however, these may have been allocated to the wards or specialties that provided palliative care for patients.

(Source : Routine Provider Information Request (RPIR) P62 Compliments)

We observed a number of thank you cards in areas we visited, however; staff did not record these on their electronic system.

Is the service well-led?
Leadership

There was one palliative care consultant who led the end of life service trust-wide. Changes in the executive team meant that it was not clear who championed the service and represented on the executive board. In addition, there was no service improvement lead for the service. However, senior leaders of the service stated they felt there was appropriate support in place for escalation of any issues currently.

Following the inspection, the trust told us that the chief nurse was the executive lead as well as the interim medical director being executive lead for mortality.

There was a non-executive director (NED) who was nominated to be responsible for end of life care. The consultant told us that the NED was supportive when needed.

The mortuary was led by pathology services as part of a regional service. Mortuary staff worked closely with the bereavement officer, who was managed under the surgical directorate.

The end of life clinical co-ordinator based at Scunthorpe Hospital and providing cover for a current vacancy at DPoW was managed within the nursing directorate.

Specialist palliative care services and rapid discharge service provided at DPoW were delivered by Macmillan nurses, in a service level agreement (SLA) with an external provider. Whilst there was a SLA in place, arrangements for out of hours support were insufficient. There was an over-reliance on the consultant in palliative care for all leadership, vision and strategy.

Following the last inspection, a strategy had been developed, identifying seven different work streams for end of life services. Senior managers told us that this strategy was currently being reviewed to reflect the provision of end of life services across each of the different localities. The North Lincolnshire and Goole strategy group had been established, at which specialist palliative care services were represented.

The trust provided details of the work group programme related to the end of life strategy group. The work group programme identified various areas for development, under the following themes: communication between primary and secondary care, including co-ordination of care; better planning to reduce unplanned admissions; rapid access to care and advice; identification of patients; involving and supporting carers; and education and training. The work group programme was a working document and we saw this did not identify ongoing timescales or dates for completion.

The trust vision and values were displayed throughout the hospital and staff we spoke with were aware of these.

The palliative care consultant told us that the strategy implemented in 2016 was currently being reviewed to meet the needs of the communities served.

Culture

In all areas we visited, we found staff to be friendly, welcoming and approachable. Staff spoke passionately about their priority for providing end of life care for patients.

Mortuary and bereavement office staff demonstrated respect for the nature of the service they provided and were proud of the work they delivered day to day. Porters had a positive outlook and were motivated to provide a sensitive service when transferring the deceased.
We saw there was a positive team-working approach and senior nurses reported being proud of all staff and the care they provided. Staff told us how they would support each other in distressing situations.

Staff felt supported by their managers and felt confident to raise any concerns they may have.

We were told that senior leaders were visible and had visited their wards.

**Governance**

There was a multi-agency strategy group and a trust strategy group that met to discuss the end of life service.

We reviewed minutes of meetings provided from the Multi agency end of life strategy group that were held in June 2017, October 2017 and March 2018. These meetings alternated with the trust’s end of life strategy group meetings with minutes received for January 2018 and April 2018.

The multi-agency end of life strategy group meetings included agenda items such as DNACPR, feedback from families, anticipatory medicine and training. The minutes identified that the service does not have a policy for patients who die in transit.

The end of life team presented a quarterly update report to the trust’s quality and safety committee, the latest being May 2018.

**Management of risk, issues and performance**

A risk register was in place for end of life care. We found that risks were not always identified, for example there being one palliative care consultant.

There were no current external reviews of the service at the trust. The trust used ward level dashboards for monitoring outcomes for end of life care. Information about service performance was discussed at the end of life strategy group meetings, which shared information with the trust board.

**Information management**

End of life policies and procedures were available for staff to view on the trusts intranet. Each ward had a resource folder containing paper copies, however; we found that the policies for anticipatory drugs and pain and symptom management in last days of life” included a review date of December 2017. There were updated current versions available on the trust intranet. We saw that the trust’s care in the last days of life guidance for professionals document also referenced the trust policy on anticipatory drugs prescribing, due for review in December 2017.

Patient records were paper-based including the last days of care documentation and the do not attempt to resuscitate form. The Haven team had access to electronic systems for referral to community staff, Macmillan nurses and GPs.

**Engagement**

End of life link nurses shared information from end of life meetings with other ward team members, the end of life clinical co-ordinator explained that attendance at meetings was low during times of hospital pressures.
During 2017 the service had held an end of life conference that included presentations from hospice staff, dementia leads and trust staff. This had been positively evaluated by staff who attended and the service was planning another similar event. The service was also preparing for ‘dying matters’ week with events organised to raise public awareness.

A newsletter for end of life was developed by the end of life co-ordinator and shared with staff throughout the trust providing information and updates about the service provided.

**Learning, continuous improvement and innovation**

Latest guidance was discussed in end of life meetings, although implementation was prioritised due to the constraints of the service.

There were plans to launch the recommended summary plan for emergency care and treatment for patients (ReSPECT); however, service leads were unable to confirm a date for this launch. ReSPECT is a process that includes personalised care for a person’s clinical care in a future emergency in which they are unable to make or express wishes. It provides health and care professionals responding to an emergency with guidance to help them make decisions about care and treatment.

There were plans to share the trusts electronic palliative care template with GP’s leading to the setting up of an electronic palliative care co-ordination system (EPaCCS). Trust leads were unable to confirm the timescales for this development.

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**Outpatients**

**Facts and data about this service**

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

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

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

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

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

**Total number of appointments compared to England**

The trust had 385,505 first and follow up outpatient appointments from November 2016 to October 2017. The graph below represents how this compares to other trusts.
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from November 2016 to October 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>216,993</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>169,060</td>
</tr>
<tr>
<td>Goole &amp; District Hospital (Acute)</td>
<td>34,481</td>
</tr>
<tr>
<td>This Trust</td>
<td>420,534</td>
</tr>
<tr>
<td>England</td>
<td>103,843,026</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from November 2016 to October 2017. The percentage of these appointments by type can be found in the chart below:

The number of appointments at Northern Lincolnshire and Goole NHS Foundation Trust from November 2016 to October 2017 are shown by site and type of appointment.
Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

There is only one medical/dental staff member allocated to outpatients in the data received from the trust. This member of staff has completed seven out of 10 modules, all with a 100% completion rate. Three modules were not completed.

A breakdown of compliance for mandatory courses for nursing staff in outpatients from February 2017 to January 2018 shown below:

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>34</td>
<td>34</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>34</td>
<td>34</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>33</td>
<td>34</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>32</td>
<td>34</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>31</td>
<td>34</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>31</td>
<td>34</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>30</td>
<td>34</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>30</td>
<td>34</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>39</td>
<td>45</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>29</td>
<td>34</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing staff at Diana Princess of Wales Hospital met or exceeded the trust's 85% completion target for all mandatory training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with told us that mental health training was provided as part of mandatory training at the trust.

Staff we spoke with told us they had no difficulty accessing training courses. Some training had been cancelled due to winter pressures but staff were booked to attend future sessions.

Mandatory training records were managed centrally, but we saw outpatient’s managers also kept local training records and received updates on staff attendance through the trust’s electronic staff record (ESR) system. Staff were booked to attend future courses to ensure compliance for all training.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

There is only one medical/dental staff member allocated to outpatients in the data received from the trust. This member of staff has achieved 100% completion for all three safeguarding modules.

A breakdown of compliance for safeguarding courses for nursing staff in outpatients from February 2017 to January 2018 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>32</td>
<td>34</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>32</td>
<td>34</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>32</td>
<td>34</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff at Diana Princess of Wales Hospital met or exceeded the trust's 85% completion target for all safeguarding training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

All staff we spoke with were able to describe their responsibilities regarding safeguarding concerns. They were able to give examples of the types of abuse, for example, neglect, physical, domestic violence, sexual and psychological abuse. Staff gave us specific examples of safeguarding concerns they raised. Staff were clear how to escalate issues and felt they were well supported if they needed to discuss any concerns.
The trust employed a safeguarding lead and supervisors across the department provided safeguarding information and support to staff.

We saw that staff had access to safeguarding policies. This also included guidance for staff regarding abuse such as female genital mutilation (FGM). FGM is defined by the World Health Organisation as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’.

Children attended some clinics, within the main outpatient department, for example orthotics. The numbers of children attending were significant. The service met the requirements of the Intercollegiate Document, third edition (March 2014) made recommendations regarding the level of training and responsibility of healthcare staff.

**Cleanliness, infection control and hygiene**

All areas we visited were visibly clean and tidy.

We saw cleaning schedules were in place to ensure rooms were clean prior to the clinic start times. Domestic staff we spoke with told us they used cleaning schedules and checklists to follow. We saw checklists were signed and up to date. All the rooms in main outpatients had been cleaned on the day of the inspection.

In the areas we visited, all seating in the waiting areas and couches in the consulting rooms were in good condition without rips and tears and were wipe clean. The areas were free from clutter and there was sufficient space for patients and staff to move freely. There were some designated waiting areas for patients with children and we saw these areas were clean and toys were clean. Staff we spoke with told us they were responsible for cleaning toys; however, we did not see cleaning records for this. There were no specific outpatient clinic rooms for patients with infectious diseases.

We saw that staff adhered to bare below the elbow protocols.

We saw clinic staff participated in hand hygiene audits and compliance was 100% for every month.

**Environment and equipment**

Staff in the ophthalmology clinic could request equipment for bariatric patients from another ward at the hospital if they required it.

Staff we spoke with told us and we saw some areas of the building were old and several reports had been made to estates for repairs to be carried out, in particular to the toilet areas. All of the rooms we saw were light and airy.

Resuscitation equipment was available on trolleys at various locations in the main outpatient areas and near other clinics. Daily checks were completed and tamper proof numbered tags were used to show if the contents had been accessed. Full internal checks of the trolleys were completed weekly. We examined the checklists of trolleys and saw that appropriate stock was in place and was regularly updated.

Utility rooms were visibly tidy and equipment was stored appropriately. Sharps bins were checked throughout the outpatient areas and all were appropriately labelled, signed and the contents were all below the fill lines. We saw that waste bins were available to enable waste to be segregated appropriately.
All staff we spoke with told us they had sufficient personal protection equipment (PPE) such as gloves and aprons.

Equipment we observed was visibly clean and staff used ‘I am clean’ stickers to show when items had been cleaned.

We checked a range of items including, syringes and dressings. We found all items were within expiry date and staff confirmed that processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

Medical equipment was serviced on site. Staff we spoke with told us that technicians usually responded quickly to requests for checks and repairs. We checked six pieces of equipment and saw that they were clean, within service date and were safety tested.

An outpatient patient survey provided by the trust highlighted that 93% of respondents found the environment in the waiting room pleasant and comfortable. The year the patient survey was carried out was not provided by the trust.

**Assessing and responding to patient risk**

At our last inspection in 2016, the outpatient management team told us they had developed a clinical validation policy that had been agreed by all specialities to manage the risks posed by lengthy waiting lists.

They told us clinical staff were validating waiting lists with a view to prioritising patients for clinic review and discharging patients where appropriate. Alongside this, administrative staff had reviewed waiting lists to cleanse data; for example, ensuring those patients not requiring follow up were removed. At this inspection we were told similar information but some staff we spoke with explained the work had been completed and finished as a single project and not maintained. This meant that new waiting lists had developed and staff we spoke with at this inspection provided the inspection team with different figures and measures relating to numbers of new and follow up patients waiting for appointments. We were not assured that there was clear oversight of the waiting lists and the risk posed to patients.

Following our inspection, the trust provided information which showed that waiting lists continued to be reviewed on a regular basis and a daily validation report was in place.

At our last inspection we noted the centralised clinical administration appointment bookings team was significantly under established and did not have the training and support in place for their roles and responsibilities. At this inspection staff we spoke with told us that around 400 staff had received referral to treatment training. We noted these staff were administrators and not clinicians. Staff we spoke with could not give us a definitive explanation as to which staff were validating waiting lists.

Staff we spoke with told us a clinical harm review was being carried out for all patients on waiting lists. Managers we spoke with told us clinical validation was ongoing in a number of specialities and specialty consultants were responsible for the validation and how they mitigated the risks. However, it was not clear if this had commenced in all specialties. Senior managers we spoke with told us that any patient waiting over six months would receive a clinical harm review and that this was carried out by the specialities.

The clinical harm group identified that 181 patients had died whilst waiting for a follow-up appointment. At the time of inspection staff told us there had been no formal reviews of these deaths to see whether the delay in appointments or treatment may have contributed to the patient deaths.
The Trust created a new post to manage clinical administration and patient access. A Project Director had been appointed on a fixed term basis to manage the clinical harm project. They had introduced an electronic reporting system to identify all patients requiring review and a new outpatient data collection form for all clinic staff to use to ensure all follow up information was available. Patients were asked to hand their form to the clinic reception staff following any outpatient appointment. Staff spoke with told us they were confident this new system ensured patient details were captured and follow up arrangements were made before patients left the department. They felt this process would prevent any more patients being lost to follow up. However, staff did explain that numbers of patients waiting for appointments were increasing month by month.

At our last inspection we noted discharge and referral data showed an initial peak of activity where numbers of discharges declined then started to rise again, gradually reaching a peak in September 2016. This corroborated what staff had told us about clinical validation of waiting lists stalling for several months following the initial activity following our last inspection. This appears to have been a repeating pattern over the last three years with a lack of progress made because once numbers were reduced the project was closed. This lack of progress meant that numbers of patient waiting for follow up appointments continued to accumulate and at this inspection numbers were higher at 31,295 in March 2018.

At our last inspection managers told us that work with NHS Improvement (NHSI) had included looking at the reasons why there was a mismatch between demand and capacity, quantifying the capacity and demand in each speciality and risk rating each of the specialities. At this inspection specialty managers told us meetings were being held with managers, consultants and administration staff to review the waiting list position and to manage and prioritise capacity and demand for appointments.

The trust had appointed a cancer project lead in October 2017 whose role was to address diagnostic delays and the trust’s decline in performance for 62 day waits for treatment for cancer patients. They told us their aim was “to change the outcome in some troubled specialties”. Staff we spoke with told us the trust used cancer service coordinators to input patient details and multidisciplinary teams (MDTs) worked together to assess individual patient needs. However, the trust cancer lead told us they estimated only 20% of clinicians and 50% of specialist nurses took part in cancer MDTs. They reported difficulties in getting clinicians to mark test requests with the correct priority therefore possibly delaying diagnoses.

Staff we spoke with reported long waiting times within specialties such as cardiology. They were seeing an increase in the number of cardiology patients waiting so long for pacing appointments they were being admitted acutely with urgent requirements.

At our last inspection, managers told us staff were ready to start real-time validation of patient tracking lists (PTLs). This would ensure waiting lists were managed appropriately and the quality of data input would be improved and prevent issues such as no due date and pathways being left open incorrectly. At this inspection staff we spoke with told us this work was continuing and they felt this ensured that patient outcomes (e.g. whether discharged or for further investigation, treatment or appointment) were correctly coded.

Staff we spoke with told us that if a patient became unwell during clinic they would seek immediate assistance from medical staff in the department. The patient would then be transferred to the emergency department for assessment.

In the case of a patient collapse in the outpatient department, all staff we spoke with were aware how to raise the alarm and raise a cardiac arrest call. Staff we spoke with told us if they needed help with a situation they could call switchboard for the crisis team or security.

Specialist nurses in diabetes and urology gave patients their contact details so they could escalate
any change in condition or seek advice when they needed to.

Staff we spoke with told us they had introduced an adapted ‘World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery’ prior to performing invasive procedures such as biopsies and intravitreal injections with a future plan to roll it out for outpatients. We reviewed eight sets of patient notes but did not see the checklists used.

Staff we spoke with told us there was no formal process or policy to manage patients who did not attend their appointment. However, they did tell us if children did not attend an appointment they would refer the family to the trust safeguarding lead. However, following our inspection, the trust provided evidence of a policy and standard operating procedure for the management of patients who did not attend appointments.

Staff we spoke with did not know of any formal process to follow for patients requiring mental health support or those living with learning difficulties. We observed staff relied on carers to provide information about patient needs and when we checked patient records we found no entries relating to individual patient needs. Staff we spoke with told us they could contact the trust’s learning disabilities lead for guidance.

**Nurse staffing**

The trust has reported their staffing numbers below for the period from January 2017 to January 2018 for outpatients.

<table>
<thead>
<tr>
<th>Site</th>
<th>January 2018</th>
<th>January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned staff – WTE</td>
<td>Actual staff – WTE in month</td>
</tr>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>10.5</td>
<td>11.3</td>
</tr>
</tbody>
</table>

In January 2018 the trust had a nursing and midwifery staff fill rates of over 100% in outpatients, this was more WTE staff in post than the trust planned to provide safe and effective care. For the previous year (January 2017) Diana Princess of Wales Hospital had slightly less establishment of nursing and midwifery staff than planned.

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

Outpatient managers managed nurse and health care assistant staffing levels depending on what clinics were running each day. Staffing was planned with individual specialties and was flexible to meet the clinic needs. Managers told us staffing had not changed for a significant length of time but they expected the capacity and demand review would help to plan staffing in future.

The matron was newly appointed and had been in post for only four weeks at our inspection. They managed 100 registered nurses and health care assistants over the whole of the clinical support directorate.

The trust provided information on cardiac physiologist staffing levels; however, this did not state the planned staffing requirement. This information showed one whole time equivalent band six vacancy was covered by agency staff and one whole time equivalent band six post where an
apprentice was due to start in September 2018. There was another 0.8 whole time equivalent staff vacancy and this was covered by agency staff from May 2018.

In echocardiography, the trust provided information showing there was 0.71 whole time equivalent band seven staff and one whole time equivalent band six staff vacancies.

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 2.3% for nursing & midwifery staff in outpatients;

- Diana, Princess of Wales Hospital: 1.2% - below trust target of 6.3%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

All senior staff we spoke with were aware of their vacancies at each clinic. Staff we spoke with told us that shifts were covered internally and no agency staff were used.

Patients we spoke with told us they thought there was enough staff in the areas visited.

**Turnover rates**

From February 2017 to January 2018, the trust reported a turnover rate of 23% for nursing & midwifery staff in outpatients;

- Diana, Princess of Wales Hospital: 21%

All three sites did not meet the trusts turnover target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From January 2017 to December 2017, the trust reported a sickness rate of 5.8% for nursing & midwifery staff in outpatients;

- Diana, Princess of Wales Hospital: 7% - above trust target of 4.1%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Staff at Diana, Princess of Wales Hospital explained there had been a higher than usual sickness and turnover rate due to some long-term sickness.

**Bank and agency staff usage**

From February 2017 to January 2018 the trust did not employ any bank or agency staff within outpatients.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

There were four whole time equivalent (WTE) phlebotomists which covered outpatients. Staff we spoke with in the oncology outpatients told us they were currently fully staffed and there was low turnover of staff in the service.
Medical staffing

Medical staffing levels were managed by the individual specialities across the trust. Some specialties reported several consultant vacancies with posts proving very difficult to fill and we saw this had a direct effect on the trust’s ability to manage new and follow up appointments.

Records

All patient records were paper based. However, patient letters including referral letters and all diagnostic results were easily accessible via electronic systems. Staff we spoke with told us that if records were not located before a clinic then the administration team would make up a temporary set of records, which would be merged, with the original set when located.

The trust did not collect data regarding the percentage of patients seen without a full medical record. However, staff we spoke with told us this rarely happened and there was an escalation process in place for them to use when notes were unavailable for clinics.

We looked at the medical records of eight patients attending outpatient clinics. We found these were of a poor standard with poor legibility and very scant information recorded, in particular by doctors regarding follow up appointments. This was not in line with professional standards or trust policy.

Record entries were mostly signed and dated but staff designations and times were missing. They contained up to date information about patients including referral letters, copies of letters to GPs and patients, medical and nursing notes.

At our last inspection we reported medical records were not stored securely. At this inspection staff we spoke with told us they did not carry out records storage audits but records were always locked away or covered and never left unattended. However, we found three separate areas in outpatient clinics where medical records were left uncovered, unsupervised and in open areas. To ensure confidentiality and data protection when not in use all medical records should be kept secure, in a locked room and away from public areas. Staff we spoke with told us they had looked into purchasing covers for notes trolleys but they had been unable to find anything suitable. Therefore, we found notes on open trolleys, stacked on the floor and stored in an unlocked room. We raised our findings with senior staff during our inspection but found on our return to the site the following day only one of these concerns had been addressed.

Medicines

Medicines in most areas were stored in locked cupboards and refrigerators. However, in one clinic area we found medicines stored in an unlocked box on the floor in an open room. Staff we spoke with told us the box contained only drugs used for the clinic and it was stored there for ease of use during the clinic to save staff having to walk to the locked cupboard at the end of the corridor.

We checked a range of medicines and found them to be in date and stored appropriately. Nurses who required access to medicines cupboards carried individual keys.

No controlled drugs (CDs) were stored in the areas we inspected.

Staff monitored and recorded the temperature of the rooms where drugs were kept. We reviewed the temperature records in clinic rooms and saw that daily checks had been completed. We saw the temperatures were within acceptable limits. Staff we spoke with could explain the process to follow should temperatures fall outside the required range.
Clinicians used a mixture of electronic prescribing and FP10 prescriptions. The FP10 prescriptions were securely stored in a locked cupboard. Prescription records were kept securely and separately from prescription books.

We saw a number of patient group directions (PGD) were used across a number of clinics, including ophthalmology and cardiology. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2017 to December 2017, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from January 2017 to December 2017.

Both incidents were classified as treatment delay meeting SI criteria with two (100% of total incidents).

The CQC received information on 19 June 2018 that the trust declared a serious incident on 18 May 2018 that was found during a validation exercise. A patient had been missed from the cancer tracking system and was treated on a routine 18-week pathway but went on to be diagnosed with cancer. The patient did not receive treatment until day 212 in their pathway.

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with told us that they were able to log onto the intranet and review never events and serious incidents across the trust and the learning from these incidents. Staff shared learning from incidents across the outpatient departments of three hospitals within the trust. Managers shared alerts and actions for change following incidents with staff at formal meetings and managers’ rounds at the start of each shift.

All staff we spoke with understood the incident reporting process and described how they would report an incident. Staff we spoke with told us that incidents were shared through emails and staff handovers where staff received feedback on incidents and learning was shared.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Local policy and national documents relating to duty of candour were available via the trust intranet. Staff we spoke with were aware of the need to be open and honest when something went wrong.
Safety thermometer

The safety thermometer was not use in outpatients. However, outpatients did record and display hand hygiene audit results. Senior staff completed a monthly ‘A3’ outpatient dashboard that showed performance data which was shared with staff and trust management.

Is the service effective?

Evidence-based care and treatment

Staff had access to a trust intranet which contained the trust policies and procedures available to staff. Staff we spoke with told us they worked within standards and guidance applicable to their practice.

Audit was generally carried out within the specialities that provided outpatients. Staff we spoke with told us they were notified of audit requirements from the trust's governance team. Staff in ophthalmology told us they participated in national audits, for example the national cataract audits. Podiatry took part in national audits such as a diabetic foot audit annually and we were told the results were above the average nationally. The podiatry team were part of a clinical network for diabetic foot conditions. Cardiology outpatients took part in audit such as the national cardiac rehabilitation audit.

Respiratory outpatient’s staff we spoke with told us they participated in national audits such as the asthma audit and chronic obstructive pulmonary disorder audit. Staff in the ear, nose and throat clinic told us they completed scope audits to check cleanliness.

We were told during our inspection that national audits were generally managed at trust level and staff would be informed when audits were required to be completed. Senior managers told us that outpatients was part of the clinical support services audit programme.

The podiatry team had a set referral pathway for the service and diabetic foot pathways for example.

Nutrition and hydration

Staff we spoke with in outpatients told us they were able to provide drinks to patients who had waited a long time or who required a drink. They were also able to provide food to patients if required in the outpatient clinics. Some areas we visited had water dispensers available.

Pain relief

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

Patient outcomes

Audits were carried out in outpatients but these were managed by the individual specialities providing the clinics. Outpatients as a service did not generally monitor patient outcomes. Patient outcome data was managed by the individual specialities.

Follow-up to new rate

From November 2016 to October 2017,

- The follow-up to new rate for Diana, Princess of Wales Hospital was similar to the England average.

Follow-up to new rate, Northern Lincolnshire and Goole NHS Foundation Trust.
Competent staff

Staff we spoke with told us they received training in addition to their mandatory training. Staff we spoke with told us they had received annual appraisals. Some staff in ophthalmology had completed dementia training to provide further understanding of dementia, training on eye drops and visual field test competencies.

We were told that phlebotomy staff completed internal training and had reviews of competency every two years. There were two stages of training which included theory and practical training. Pathology offered training to different staff in the department.

Some staff we spoke with told us they received clinical supervision and other staff had been supported to complete prescribing courses and additional studies.

Around 400 staff in the service had completed training in referral to treatment indicators and the access policy to increase their knowledge of these.

Senior managers we spoke with told us there was line manager training available.

A performance report for outpatients in February 2018 showed that 97% of staff had completed a personal annual development review against a target of 95%. The April 2018 performance report showed that 89% of outpatient staff were compliant against a target of 95%.

Some staff attended external regional meetings applicable to their practice.

Appraisal rates

From April 20176 to March 2017, 100% of nursing staff within outpatients at the trust had received an appraisal, this met the trust target of 95%.

A breakdown by site is shown below;

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
</table>

(Source: Hospital Episode Statistics)
<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Count</th>
<th>Percentage</th>
<th>Score</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of</td>
<td>13</td>
<td>13</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
<tr>
<td>Wales Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goole District</td>
<td>3</td>
<td>3</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scunthorpe General</td>
<td>13</td>
<td>13</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>29</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Ophthalmology had multidisciplinary team meetings which were held at Scunthorpe Hospital and oncology had multidisciplinary team meetings at each site. The podiatry team had multidisciplinary team meetings which included staff from the diabetes speciality.

There was a twice weekly multidisciplinary team meeting in cardiology which included cardiac physiologists, cardiac rehabilitation nurses and consultants.

Clinical nurse specialists were available in a number of clinics visited to provide further support and advice to patients. There was multidisciplinary team working in outpatients with medical staff and nursing staff working together along with clinical nurse specialists in departments such as cardiology.

**Seven-day services**

Seven-day services were generally not provided by outpatients.

Managers told us the pathology laboratory was open 24 hours a day with on-call staff available.

**Health promotion**

Outpatients had held smoking cessation groups. There were patient information leaflets available in different outpatient specialties.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff we spoke with in ophthalmology told us they had recently received mental capacity act training. Staff in ear, nose and throat outpatients told us they completed mental capacity act training as part of mandatory training.

The oncology pre-assessment clinics had consent paper work for use in clinics. Staff we spoke with were able to talk about taking consent. Podiatry and therapies used electronic record systems and this allowed consent to be recorded on the system.

The trust provided details on mental capacity act training compliance for outpatients. This showed 81.7% of staff had completed this training against a trust training target of 95%.
Is the service caring?

Compassionate care

During our inspection we heard staff introducing themselves to patients in clinics. Staff in ophthalmology told us they introduce themselves to patients before entering clinic rooms.

We observed staff of all grades interacting with patients. Staff introduced themselves, were friendly and welcoming and were quick to offer help when required. The outpatient survey showed that 86% of respondents stated that staff members introduced themselves when they came into direct contact with them. The outpatient survey did not detail the date of the survey.

Administrative staff, volunteers and nurses all greeted patients on arrival to main outpatients. Staff were friendly and helpful and we observed staff go out of their way to offer assistance.

We spoke with 17 patients and four relatives and those close to them. Overall, the feedback was positive and staff were described as being caring and considerate. Patients we spoke with told us they felt supported and treated with dignity and respect.

Staff we spoke with told us they ensure privacy and dignity by ensuring clinic rooms doors were closed during clinics.

The trust provided an outpatient department patient questionnaire for DPoW; however, this did not have a date attached. One hundred percent of respondents felt they were treated with dignity and respect. Forty three percent of respondents said their overall experience on the day was excellent, 48% stated good and 9% stated average.

Emotional support

Clinical nurse specialists provided additional support and in-depth knowledge to patients with a range of conditions and disease specific information. Staff we spoke with told us about specific support they provided such as catheter care for urology patients. Staff provided a wide range of leaflets to support patients at appointments and to enable self-care at home.

We saw information about the availability of chaperones in the main outpatient waiting room. Staff we spoke with told us that they were able to provide a chaperone when it was required. The majority of outpatient staff were female but there were male members of staff available when requested.

Patients we spoke with told us they felt involved in the planning of their care.

Understanding and involvement of patients and those close to them

We observed staff interacting with patients and relatives in clinics and imparting information in a way that was appropriate for the patient’s understanding.

Patients received a copy of the letter sent to their GP following consultations. This ensured that patients were kept up to date with all decisions made about their care.

Staff directed patients to a range of appropriate support agencies and self-help groups.

The trust provided an outpatient department patient questionnaire for DPoW; however, this did not have a date attached. This showed that 64% of respondents felt relaxed regarding their
experience of the department, 20% had a reasonable experience, 8% felt nervous and 8% felt staff did their best to put them at ease.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Volunteers were available at main reception to assist people with directions at the hospital. Patients could check in at a reception desk or use the electronic check in desks at the entrance to outpatients. There were seating areas in the different outpatient areas at the hospital; however, there were no bariatric chairs available for use in waiting areas in outpatients.

Ophthalmology outpatient clinics times were Monday to Friday 8:30am to 6pm. Outpatient clinics generally were open between 8am and 4:30pm Monday to Friday. The phlebotomy service was available in outpatients between 8am and 5pm Monday to Friday.

Phlebotomy outpatients had seating available for patients and a reception desk for patients to book in. Podiatry outpatients had water available for patient use, patient information leaflets, for example on diabetes, magazines in the waiting room and seating for patients waiting for clinics.

Outpatient clinics could offer patients a bleep if the waiting times in clinic were long and staff would call the bleep when their appointment was ready.

Senior managers we spoke with told us they met regularly with the clinical commissioning groups regarding service delivery and attended regular business meetings for outpatients. Capacity and demand was managed by individual specialities.

There were limited clinics which had put on extra evening and weekend clinics to address backlogs and provide additional appointments. Ophthalmology had two evening clinics a week on a Monday and Tuesday between 5pm and 8pm. Staff we spoke with told us these clinics were well attended. There had also been additional evening clinics arranged for colorectal outpatients.

Virtual clinics were provided in ophthalmology by the medical illustrator service who completed a visual acuity test, scan and optical coherence tomography (OCT) which is an imaging technique and these were then reviewed by a consultant a few days later. There were four virtual clinics each week. Staff we spoke with told us there was a new virtual clinic being initiated for diabetic patients. These virtual clinics did require the patient to attend clinic.

**Meeting people’s individual needs**

Bariatric equipment was not routinely available in ophthalmology outpatients; however, staff could request bariatric equipment from another ward if required.

Outpatient clinics we visited had a range of leaflets available for patients. Some areas provided these leaflets in different languages.

Staff in oncology outpatients told us they provided information leaflets to patients when attending clinics. A number of patient information leaflets were available in oncology outpatients and other outpatient departments.

Oncology outpatients and general outpatients had quiet rooms available for patient use. The oncology outpatient department waiting room had access to a garden. There was day care in oncology outpatients with beds, chairs and a side room if required.

Ear, Nose and throat outpatients had access to a quiet room for patient use.
There were specialist nurses available in a number of outpatient clinics, for example cardiology outpatients and ear, nose and throat outpatients.

Cardiology outpatients held an exercise programme twice a week with physiotherapy.

Some areas had dementia friendly environments, for example clocks and toilet signage. Staff we spoke with in outpatients told us that they would try to get dementia patients into clinic as promptly as possible and would ensure a quiet area was available for use if required. There was a dementia team in the trust that staff could call for advice.

Staff in ophthalmology told us they were able to provide a quiet room for vulnerable patients attending clinics and were able to prioritise vulnerable patients if required.

There was no direct access to mental health advice for staff in outpatient departments. Staff would refer patients to the emergency department if required.

We saw patient information leaflets were available in different languages, for example a leaflet about the management of tuberculosis (TB) was available in a different language.

### Access and flow

The previous inspection found concerns with waiting lists and referral to treatment indicators. During this inspection we found there were still issues and concerns around waiting lists for appointments and most specialities were not achieving their referral to targets indicators.

The planned care key performance indicator dashboard showed there were 31,295 follow up outpatients overdue as at March 2018. Senior managers told us that around 14,518 of these were part of the clinical harm review and 6,000 were patients who did not have a review date assigned. The previous inspection found that not all patients had a due date on the patient administration system. During this inspection, senior managers told us there were still patients without a due date on the patient administration system; however, managers told us they knew who these were and were working through the 6,000 patient backlog for due dates. We were told 2,000 of these patients could not have a due date for follow up appointments as they were waiting for an inpatient episode.

The planned care key performance indicator dashboard April 2017 to April 2018 showed there were 320 patients waiting over 52 weeks for an appointment at the trust as at March 2018.

The previous inspection found that the trust aimed to achieve their referral to treatment required position by March 2018. During this inspection, this had not been achieved and senior managers told us there was an action plan for medicine and surgery but the trajectory for improvement and for achieving the referral to treatment indicators and follow up appointments would not be decided until the end of quarter one (June) 2018. Senior managers told us there had been some recent improvement in cardiology where the backlog was 3,600 waiting for follow up appointments and the service had reduced this to 3,300 in the previous six weeks.

Cardiology held one stop clinics where they saw a number of patients to assist in addressing capacity and demand issues. These had occurred monthly and had only recently started. There was also a rapid access clinic twice a week in cardiology for referrals from general practitioners.

The services had worked with the intensive support team to create a capacity and demand model and the focus initially was on the eight most challenged specialities. The capacity and demand plans were being completed by individual specialities at the trust.

The trust provided an improving together programme document for the outpatients and patient
access work stream highlight report which showed information such as key activities last month and next month, key performance indicators and top risks and issues.

The trust provided a project document for the outpatients. This detailed the project brief and work stream risk log. The trust also provided a project brief for outpatient efficiencies and patient access which was dated October 2017 and included a project plan.

The previous inspection found issues with the trust’s recording of some referral to treatment indicators in outpatients. Senior managers told us that they had started to audit recording of some indicators and waiting lists at the trust; however, this had only happened in five specialities at the time of the inspection.

Individual clinics and specialities booked appointments for patients and patients would contact these clinics directly if required. Staff we spoke with were aware there were long waiting times for clinic appointments.

The phlebotomy team used an electronic system which detailed waiting times for blood tests and if the waiting time reached 30 minutes, more staff would be asked to assist the team. Staff tried to keep the waiting time in phlebotomy to 30 minutes or under. There were areas visited during the inspection where clinics were running late and we were told in some areas such as ophthalmology this was a regular occurrence. During our inspection there was a 70 minute wait during an ophthalmology clinic.

We saw in outpatient clinics we visited that staff would highlight the waiting times for clinics on display boards in the waiting areas. Staff would also inform patients verbally if the wait in clinic was longer than expected.

The April 2017 to April 2018 outpatient key performance indicator dashboard showed a target of 95% for outpatient’s clinic slot utilisation rate and this was 85.7% for DPOW Hospital. This was worse than the trust target.

The April 2017 to April 2018 outpatient key performance indicator dashboard showed a target did not attend rate of 5% and the dashboard showed that the twelve months total for DPOW hospital was 7.9%. This was worse than the trust target.

The April 2017 to April 2018 outpatient key performance indicator dashboard showed a target of 7.5% for hospital cancellations under six weeks and the dashboard showed that the twelve months total for DPOW was 5.6%. This was better than the trust target.

The trust had a key performance indicator for appointment slot issues and the outpatient dashboard April 2017 to April 2018 showed a target of 4% and the dashboard showed that the twelve months total for DPOW hospital was 26.3%. This was worse than the trust target. The April 2017 to April 2018 outpatient key performance indicator dashboard showed the outpatients booked slot utilisation rate was below the trust target of 95%. In April 2018 at DPOW it was 87%.

Senior managers told us some clinics had been reduced during the winter pressures. Senior managers also told us they now had a patient access policy.

The trust provided details of clinic cancellations in outpatients, for example in December 2017, 402 patients appointments were cancelled which was 4.5% of total patients. During January 2018, 692 patient’s appointments were cancelled or 6.8% of total patients. During February 2018, 1130 patient’s appointments were cancelled or 10.9% of total patients. During March 2018, 834 patient’s appointments were cancelled or 7.7% of total patients in outpatients.

An outpatient patient survey at DPOW showed that 40% of patients waited 0 – 15 minutes longer
than their appointment time, 16% of patients waited 15 – 30 minutes longer, 12% of patients waited 30 – 45 minutes longer, 4% of patients waited 45 – 60 minutes longer and 8% of patients waited 60 minutes or longer. No date was attached to the survey.

The same outpatient patient survey showed that 86% of respondents were given an explanation of the appointment delay by staff.

**Did not attend rate**

From November 2016 to October 2017,
- The ‘did not attend’ rate for Diana, Princess of Wales Hospital was higher than the England average.

All three sites are generally higher than the England average from November 2016 to October 2017.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Northern Lincolnshire and Goole NHS Foundation Trust.

![Graph showing did not attend rate](image)

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for November 2017 showed 75.3% of this group of patients were treated within 18 weeks versus the England average of 88.8%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Northern Lincolnshire and Goole NHS Foundation Trust.

![Graph showing referral to treatment rate](image)
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

One specialty was above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>98.8%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>97.4%</td>
<td>93.8%</td>
</tr>
</tbody>
</table>

Fourteen specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>86.5%</td>
<td>88.1%</td>
</tr>
<tr>
<td>Other</td>
<td>86.1%</td>
<td>91.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>83.8%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>83.0%</td>
<td>87.2%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>82.2%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.5%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>76.3%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>72.1%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>72.0%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>71.0%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>70.3%</td>
<td>90.2%</td>
</tr>
<tr>
<td>ENT</td>
<td>69.3%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>63.7%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Neurology</td>
<td>24.5%</td>
<td>32.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance.

In the latest month, November 2017 73% of this group of patients were treated within 18 weeks compared to the England average of 89%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways,
Northern Lincolnshire and Goole NHS Foundation Trust.

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

One specialty was above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>96.6%</td>
<td>90.6%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

(Credit: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Northern Lincolnshire and Goole NHS Foundation Trust

(Credit: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Northern Lincolnshire and Goole NHS Foundation Trust
The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

![Graph showing performance comparison]

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Northern Lincolnshire and Goole NHS Foundation Trust

![Graph showing performance comparison]

(Source: NHS England – Cancer Waits)

During our inspection senior staff we spoke with told us there was no current target date for improvement of the 62 day wait and an action plan was being developed to address the issues.

Learning from complaints and concerns

Summary of complaints

Outpatient services trustwide

From February 2017 to February 2018 there were 156 complaints about outpatient services (32.5% of total complaints received by the trust).

The trust complaints data shows these mapped to specialities. The top specialities with most outpatient complaints were Orthopaedics with 15 complaints and Gastroenterology 12 complaints. ENT and Cardiology both had 10 complaints each.
Overall complaints about outpatient service took an average of 50 working days to investigate and close complaints. This was not in line with the trust targets for closing complaints within 30 working days, or the further target of 45 working days.

The most common subjects complained about in outpatients were patient care with 82 complaints and appointments with 22 complaints.

There was evidence of complaints which related to access to treatment in 14 complaints, for example in ear, nose and throat outpatients.

Diana, Princess of Wales Hospital:

From February 2017 to February 2018 there were 80 complaints about outpatient services at Diana, Princess of Wales Hospital.

The trust took an average of 45 working days to investigate and close complaints at the hospital. This is not in line with the trust targets for closing complaints within 30 working days, but just meets the further target of 45 working days.

A breakdown of the subject of complaints is shown below:

- Patient care – 45 complaints
- Communication – eight complaints
- Values & behaviours (staff) – eight complaints
- Appointments – seven complaints
- Access to treatment or drugs – five complaints
- Admin/policies/procedures (including patient record) – three complaints
- Waiting times – two complaints
- Integrated care (including delayed discharge due to absence of care package) – one complaint
- Privacy, dignity & wellbeing – one complaint

(Source: Trust Provider Information Request P55)

There was evidence of complaints which related to access to treatment, for example in ear, nose and throat outpatients.

Staff we spoke with told us a complaint regarding waiting times in phlebotomy outpatients had led to the service creating a waiting time monitoring system to reduce waits and alert staff to if additional staff were required. Staff we spoke with told us complaints were often regarding waiting times in clinics and told us they had changed the boards in waiting areas to include the doctor’s clinic and the waiting times.

Staff we spoke with in ophthalmology told us they often attempted to address complaints informally in clinic and that complaints were discussed at team meetings along with lessons learnt. Main outpatient’s staff we spoke with told us complaints were mostly regarding the length of time in clinic.

Is the service well-led?

Leadership
Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available for support when required. However, staff we spoke with told us senior leaders were less visible in departments. Staff views varied on the trust leadership team being visible in departments. Some staff we spoke with told us they had met some of the trusts recently appointed senior leadership.

Outpatients were part of the clinical support services directorate. There was a structure for the management of outpatients. Overall leadership was provided by the clinical support services senior management team. There was a matron for outpatients covering all sites. Diana Princess of Wales Hospital outpatient departments were managed by an outpatient’s manager and a deputy manager had recently been appointed to provide further support to the department.

The clinical services directorate management group had been formed in June 2017.

Since the previous inspection, the trust had appointed a senior manager to address concerns with patient administration. Senior managers we spoke with told us work was progressing with clinical validation and training on logging the correct follow up with patient administrators and that the focus was on stabilisation and understanding of where the trust was with waiting lists. The aim was to reduce waiting lists and ensure visibility of waiting lists in a sustainable way.

Senior managers we spoke with were aware there were challenges with waiting lists for outpatient appointments and issues with referral to treatment indicators.

**Vision and strategy**

There was no documented strategy or vision for outpatients across the trust. Most staff we spoke with were not aware of the trusts vision and values. We saw the vision of the trust on display in some areas we visited, for example in main outpatients.

Senior managers told us they were working with commissioners to address issues around capacity and demand. The trust had received previous reviews from external organisations of waiting list issues.

Senior managers told us their focus for the next twelve months was around waiting lists, managing capacity and demand, clinical harm reviews and patients waiting over 52 weeks.

The priority was to work with the patient administrative lead in outpatients to provide outpatient services. Capacity and demand was being managed by individual specialities.

**Culture**

The previous inspection found concerns around the culture of outpatients. During this inspection, most staff in departments told us there was good teamwork amongst department teams, openness and honesty in teams and overall staff were positive about working in their departments. Most staff we spoke with told us they felt supported.

Staff we spoke with told us morale was generally good; however, it could vary at different times and had been low in some services previously.

Staff we spoke with told us about of a lack of communication from the senior leadership team in outpatients.

**Governance**
Senior managers for outpatients described the governance arrangements. We were told that outpatients had a monthly governance meeting and that senior managers attended the clinical support services governance meeting. There was director level staff at this meeting where concerns and issues could be escalated to the board at the trust. The clinical support services group had a monthly meeting. Outpatient managers attended the governance meetings.

The agenda from the December 2017 and April 2018 governance meeting showed that National Institute of Health and Care Excellence, national patient safety alerts, infection, prevention and control were part of the agenda. Complaints, incidents and mandatory training were also part of the agenda for governance meetings in the clinical support services directorate.

Due to the issues around waiting lists and backlogs of patients for outpatients, the trust had started a clinical harm review group where they were reviewing around 14,000 patients for clinical harm. The previous inspection highlighted a number of issues and concerns around patients where no due date had been attached to the patient administration system, patients waiting over their due date, referral to treatment indicators not being met. At this inspection we found the management of these concerns and clinical validation had been slow to begin.

Since the last inspection, the trust had appointed a senior manager for patient administration and there was further documented information on the actual number of patients in the follow up appointment backlog and clinical harm review. We were told there were a number of different actions taking place to address the concerns and issues around waiting lists. Clinical and administrative validation of waiting lists was ongoing; however, this was not complete across all specialities at the time of this inspection.

Waiting lists were managed by the specialities they were part of, for example, medicine and surgery managed their own waiting lists.

A staff member from the phlebotomy service attended a regular clinical governance trust meeting.

There was a quality and safety meeting every two months for clinical support services.

**Management of risk, issues and performance**

Managers had access to performance information such as staffing levels and sickness levels. Each outpatient department had a monthly performance report which detailed performance information that was used during meetings.

The trust provided a performance report for DPoW outpatients department which contained information such as outpatient attendances, staffing, training and development.

The trust had failed to address concerns about waiting lists and complete clinical validation of patients in the waiting list backlog from the previous inspection in 2016. The previous inspection found that the trust was finding cohorts of patients which were not being effectively managed. We were told during this inspection that the 31,295 patients was the total number of patients in a backlog for outpatient appointments at the trust.

Outpatients had a risk register and we were told this was reviewed monthly and this was on the agenda for governance meetings. Senior managers we spoke with told us the trust had provided risk register training. The trust had an incident reporting system which staff could report incidents regarding outpatients.

Pathology services had key performance indicators which managers told us they monitored monthly. Managers told us there was a turnaround time of one hour for urgent emergency
department requests and we were told normally 90% of these were done on time. The target time for general practitioner requests to pathology was 24 hours if specialist analysis was required.

The trust provided us with an outpatient care key performance indicator dashboard from April 2017 to April 2018. This included various performance information such as did not attend rates and hospital cancellations.

The trust provided a clinical support services risk register dated June 2018 which detailed risks such as lack of capacity to cope with outpatient service demands. There were two risks documented on the outpatient part of the risk register. The risk register had review dates attached, risk levels and mitigating actions section. However, risks we found during the inspection such as patient record storage was not documented on the risk register. The trust provided information highlighting ophthalmology was part of the surgery risk register and cardiology was part of the medicine risk register.

Senior managers told us there were daily patient tracking list huddles in five specialties with team leaders, service managers and administrative staff and that each division had a weekly performance meeting.

Information management

Staff had access to electronic systems across outpatients, for example access to policies and procedures through the trust intranet and electronic incident reporting system. Managers had access to performance information such as key performance indicator dashboards. Senior managers told us there had been no recent information governance issues in outpatients.

Engagement

The trust had an open access physiotherapy service for staff and access to staff counselling.

Friends and family test surveys were carried out in outpatients; however, we did not see any results from these. Senior managers told us they also completed a quarterly patient satisfaction survey.

The trust provided information highlighting they did not complete staff surveys. Senior managers told us that the new senior leadership were meeting to work on priorities such as morale and had a listening into action campaign. There was a staff magazine and newsletter at the trust.

There had been four staff engagement workshops for the clinical administrative teams and nursing staff to address staff dissatisfaction challenges.

There were team meetings in different outpatient clinics for example in ear, nose and throat outpatients; however, some services such as ophthalmology and cardiology had not had regular recent team meetings.

Learning, continuous improvement and innovation

The podiatry team had won the star award 2017 at the trust. The ophthalmology team had also won the star award from the trust.

The pathology service was in the process of implementing a new monitoring system with a dashboard to more easily identify any issues. This dashboard would display sickness levels, complaints and compliments for example.
In ophthalmology, there had been virtual clinics for the last nine months where patients attended to see the specialist nurses.

There had been two nurse led clinics in ophthalmology for the last three weeks. This had allowed the services to see an extra 40 patients a month. There had also been a nurse led macular clinic in ophthalmology.
Diagnostic imaging

Facts and data about this service

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

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

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

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

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

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

Is the service safe?

Mandatory training

The department made sure that all diagnostics and radiology staff had undergone specific training in handling radioactive and hazardous substances in line with their roles and responsibilities. The department had produced a workbook about the dangers of working in the radiology department for all staff including domestic and portering staff to complete to ensure patient and their own safety.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training. Medical staff worked cross site and the information for medical and dental staff is for all medical staff working in the diagnostics departments at Goole (GDH), Scunthorpe and Diana Princess of Wales (DPOW).

All sites Medical and Dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control - 1 Year</td>
<td>5</td>
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<td>100%</td>
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</table>
### Diana, Princess of Wales Hospital Nursing staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety 2 years</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
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<tr>
<td>Slips, Trips &amp; Falls</td>
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</tr>
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<td>85%</td>
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<td>100%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Infection Control - 1 Year</td>
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<tr>
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<tr>
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<td>80%</td>
<td>85%</td>
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<tr>
<td>Resuscitation</td>
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<td>5</td>
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<td>85%</td>
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</tr>
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<td>Manual Handling - People</td>
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</tbody>
</table>

The overall mandatory training completion rate for nursing and midwifery staff in diagnostics was 94% at Diana, Princess of Wales Hospital with the trust target met for seven out of ten training modules.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

### Allied health professionals

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Safety 2 years</td>
<td>37</td>
<td>40</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>34</td>
<td>40</td>
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<td>85%</td>
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</tr>
<tr>
<td>Challenging Behaviour</td>
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<td>40</td>
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</tr>
<tr>
<td>Equality and Diversity</td>
<td>37</td>
<td>40</td>
<td>93%</td>
<td>85%</td>
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</table>
Deprivation of Liberty Overview

<table>
<thead>
<tr>
<th>Introduction</th>
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<tr>
<td>Moving and Handling non patient</td>
<td>38</td>
<td>40</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>35</td>
<td>40</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>37</td>
<td>40</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Harassment and Bullying awareness</td>
<td>34</td>
<td>40</td>
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<td>85%</td>
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</tr>
<tr>
<td>Information Governance</td>
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<td>85%</td>
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<tr>
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<td>31</td>
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<td>78%</td>
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<tr>
<td>Resuscitation</td>
<td>33</td>
<td>40</td>
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<td>85%</td>
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<tr>
<td>Mental Capacity Act</td>
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<td>40</td>
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</tr>
<tr>
<td>Prevent</td>
<td>27</td>
<td>40</td>
<td>68%</td>
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</tr>
<tr>
<td>Dementia Awareness</td>
<td>33</td>
<td>40</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital allied health staff met 11 of 16 training modules, failing to meet Moving and Handling of patients, Resuscitation, Mental Capacity Act, Prevent and Dementia Awareness.

Staff told us training was available however because they were busy, they sometimes were not able to attend. Staff told us they tried to prioritise training but that it was not always possible to do.

Safeguarding

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical and dental staff at Diana, Princess of Wales Hospital is below.

Diana, Princess of Wales Hospital Medical and Dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
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<tr>
<td>Safeguarding Children (Level 1)</td>
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<td>100%</td>
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</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

One member of medical staff was not up to date with safeguarding adults training. Because of the low numbers of medical staff, this meant medical staff as a group did not meet the 85% target.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for nursing and midwifery staff at Diana, Princess of Wales Hospital is below.

Diana, Princess of Wales Hospital Nursing staff
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
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<tr>
<td>Safeguarding Adults (Level 1)</td>
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<tr>
<td>Safeguarding Children (Level 2)</td>
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<td>100%</td>
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<td>Yes</td>
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<tr>
<td>Safeguarding Children (Level 1)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for nursing and midwifery staff in diagnostics was 100% at Diana, Princess of Wales Hospital with all modules meeting target.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)

Diana Princess of Wales Allied Health Professionals

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>37</td>
<td>40</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>37</td>
<td>40</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>33</td>
<td>40</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall training completion rate for allied health professional staff in diagnostics was 93% for safeguarding vulnerable children and 83% for safeguarding vulnerable adults. This meant the department was not meeting the trust target of 85% for safeguarding adults.

Staff told us how they made sure they were scanning the correct patient by using the three-point ID check. This made sure patients were not exposed to incorrect doses of radiation or unnecessary exposure. They made sure patients had the right scan first time. Staff were aware of the need to report if a patient had an incorrect scan.

Staff told us they knew about female genital mutilation and what action to take should they have any concerns about patients attending the department. There was information on the hospital intranet about how to report safeguarding concerns about patients. Staff also told us that if they were unsure what action to take, they would speak with their line manager, one of the doctors or the safeguarding team within the trust for advice.

There was information about safeguarding on the walls in the department, visible where patients, visitors and staff could see it.

**Cleanliness, infection control and hygiene**

During our inspection we looked at the cleanliness of the department. All the treatment rooms in the department were clean and uncluttered.

There were cleaning schedules in place and these showed regular cleaning of the department and the equipment being used. Staff wiped down x-ray machines between patients and used a disposable blue roll on beds. This was changed after every patient.

If a patient required isolation because of risk of infection, there were three bays with curtains that could be used. If a patient was on a ward as an inpatient and needed an x-ray or ultrasound, portable equipment could be taken to the ward. Once finished, equipment was cleaned.
thoroughly to avoid contamination.

There were some toys for children to play with. These met with infection prevention and cleanliness guidelines and were cleaned regularly.

There was sufficient personal protection equipment such as gloves and aprons available to staff. There were processes in place to manage clinical waste within the department.

Hand hygiene audits were carried out in the department to ensure staff followed the correct hand washing procedures between patients. Results were good and we had no concerns about hand hygiene practice. We observed staff washing their hands and using alcohol gel and cleaning wipes on equipment.

**Environment and equipment**

The department had resuscitation equipment in both the main radiology department and the scanning department. These were checked regularly in line with trust policy to make sure all emergency equipment was in place and in date.

There was clear signage outside and around the departments to warn staff and patients of the risks of radiation. X-ray rooms had illuminated signage to inform patients when it was safe and unsafe to enter and there were warnings for patients about MRI and CT scanner safety such as metal objects close to the MRI scanner. The signage was clear, visible and appropriate to the needs of the department.

All staff were allocated a dosimeter to wear. These were sent away regularly for monitoring and assessment. Any concerns with abnormally high doses were highlighted to the member of staff responsible. We spoke with this member of staff who described to us the action they would take if a dosimeter showed an abnormal reading. This was in line with the trust process.

All staff had lead aprons to protect them from over exposure to harmful rays. There were also aprons available for patients such as pregnant women when an x-ray was deemed as necessary, and parents or carers so they could accompany a patient into the x-ray room. We saw evidence that the protective garments were checked and removed from service when no longer offering viable protection.

We looked at COSHH (Control of substances hazardous to health) policies and found them to be in date. Any substances hazardous to health such as cleaning products were safely stored. The department used specific radiology related contrast media on this site. This was stored safely and securely in a locked environment.

Equipment in the main x-ray department was maintained in line with manufacturer requirements. There were maintenance and repair contracts in place. The medical electronics team within the trust was also able to carry out some repairs to broken down equipment.

Ultrasound equipment was new and of a high quality standard. Sonographers expressed no concerns about the capacity or ability of the equipment to fulfil their requirements.

Some of the equipment in the scanning department such as the MRI and CT scanners were classed as ‘End of Life’ This meant that spare parts were no longer made for them. When they broke down, the trust had to source second hand reconditioned parts to repair them. Staff told us these parts were unreliable and did not always have a long lifespan. DPOW had experienced significant problems with mechanical breakdowns. This affected their ability to meet demand and meet key performance indicators (KPIs) and national treatment pathway targets. The equipment was on the risk register and some funding applications had been made to purchase new equipment however, at the time of the inspection funding had not been agreed.
The scanning department also had insufficient equipment to meet demand. Scanners were working from 7am until 10pm seven days a week to try to cope with demand yet waiting lists were increasing and waiting times for scans getting longer. This was recorded on the risk register but was an ongoing problem.

According to the NHS Radiology benchmarking report for 2016/2017 activity, (the most recent report available) 20% of scanner and machines in this trust were leased. The trust was in the middle of the range of trusts who participated in benchmarking.

The same report showed the trust had more scanners than the average per 100,000 outpatient attendances (17 compared to 14). However, for A&E attendance, the trust had less scanners per 100,000 attendances, (two compared to three). For inpatients, the department had slightly fewer scanners per 100,000 bed days than the average (0.9 compared to 1).

The department had an old CT scanner which was only used in an emergency if the regular scanner was out of service and a patient attended A&E with a suspected stroke. National guidance states a patient with suspected stroke should have a CT scan within 60 minutes of arriving at hospital. This back up machine was used to ensure that any scanning delay was not due to mechanical breakdown.

Some MRI scans could not be carried out by the scanner in the department because the image quality was not good enough to scan anything other than extremities (arms and legs), spines and heads. Any ‘bodywork’, scans of the torso, were carried out on the MRI scanner based on site, hired by the trust, but owned by a private company.

At the Pink Rose suite, (the breast care service), staff told us that both gamma cameras were becoming increasingly unreliable and about to be added to the risk register. This meant the service could be left without essential equipment and was a risk to patients as multiple breakdowns meant the department had lost approximately 140 hours since January 2018.

Staff in the nuclear medicine team who carried out injections told us they needed another injection room to meet demand on the service as one injection room was not enough. There was only one injection room and demand was high however we were unable to gather any other evidence such as waiting times to support this assertion.

The department had business continuity plans in place to manage mechanical breakdown or IT system failures such as cyber-attacks. These were tested when the trust fell victim to a national cyber-attack. The department continued to function using analogue images rather than digital ones.

**Assessing and responding to patient risk**

Patients attending the scanning department requiring injection of contrast media or administration of other medication prior to their scans were scheduled to have their procedures during core hours when there was easier access to support services should patients have an adverse reaction.

Policies, procedures and local rules were in place for radiology. We checked these and found that the local rules were out of date and last reviewed in 2016 in the Pink Rose suite. Local rules elsewhere were displayed around the departments and in date.

There was a specific process in place for escalating unexpected or serious findings. This involved the radiographer requesting an urgent report and the reporting radiographer/radiologist calling the clinician who referred the patient to highlight the findings. However, we found three examples where delays to reporting, untoward findings not being escalated or changes in scans being
missed had led to delayed diagnosis and potential harm to patients. Therefore, we had concerns about the robustness of this process.

The trust had arrangements in place to seek advice from an external Radiology Protection Advisor (RPA) in accordance with relevant legislation. The hospital had a service level agreement (SLA) in place with the RPA at a neighbouring trust.

The RPA was easily accessible through regular meetings or telephone contact.

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. We saw evidence of this happening.

Radiation protection information was available in a folder and staff had all signed to confirm they had read it.

All staff were observed to be wearing body dosimeters (dose meters) on the front of their torso. A radiation dosimeter is a device that measures exposure to ionizing radiation. 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 observed diagnostic reference levels (DRLs) were on display in the X-ray rooms. Risk assessments, including COSHH risk assessments, were all up to date.

Staff described how they would ensure pregnancy tests were performed for patients aged between 12 and 55 who were unsure of their pregnancy status. We saw pictorial representations were available for people whose first language was not English.

Imaging requests, which included pregnancy checks, were scanned into the patient’s electronic records. There were referral criteria which had to be met before a referral was accepted. Not all clinical staff could make a referral. This made sure only appropriate referrals were made, thus saving resources and reducing inappropriate referrals.

Systems and processes for the management of deteriorating patients were well established at DPOW. Policies, procedures and local rules were in place for radiology. We checked and these were all in date and displayed around the departments. However, we found them to be out of date on the Pink Rose site.

There was a specific process in place for escalating unexpected or serious findings. This involved the radiographer requesting an urgent report and the reporting radiographer/radiologist calling the clinician who referred the patient to highlight the findings.

The manager confirmed the trust had arrangements in place to seek advice from an external Radiology Protection Advisor (RPA) in accordance with relevant legislation. The hospital had a service level agreement (SLA) in place with the RPA at a neighbouring trust.

The head of general radiology told us the RPA was easily accessible through regular meetings or telephone.

Radiation protection information was available in a folder and staff had all signed to confirm they had read it.

The trust had not carried out any reviews of patients who had experienced delays, to find out if the delay had impacted on their condition, treatment or prognosis. We spoke with the general manager and clinical director who confirmed this was the case.
Staffing

Nurse and allied health professional staffing

The trust has reported their staffing numbers for staff reported by the trust to be working in diagnostics below for January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>20.7</td>
<td>19.24</td>
<td>21.3</td>
<td>23.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

A breakdown of vacancy rates for nursing staff at the trust broken down by site is below. However, this information was not broken down for diagnostics and radiology which as above shows vacancies of 1.46 WTE nursing staff at DPOW as of January 2018.

Nursing staff at Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>-15.25</td>
<td>254.4</td>
<td>-6.0%*</td>
</tr>
</tbody>
</table>

*Negative numbers indicate a staffing surplus

Diana, Princess of Wales Hospital was over established by 6%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Allied Health Professional Staff at Diana, Princess of Wales Hospital

The trust sent us information to show there were 4.16 WTE vacancies across the different modalities within diagnostics and radiology however we also received contradictory information informing us that there were no vacancies in the department and general radiology was over staffed by one WTE.

Turnover rates

The trust has an annual turnover target of 9.4%.

The trust did not supply us with the turnover rate for either nurse of allied health professional staffing at DPOW therefore we were unaware of whether the department was meeting the target.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Within 12 months, 16 staff had joined the department and 10 (WTE 9) had left. This was from a total of 44.67 WTE staff.
We spoke with radiographers on site at DPOW. They told us that there was turnover of staff in plain film x-ray because people wanted to progress and felt unable to secure promotion without having to move to another modality such as CT or MRI. Staff told us that the trust was reluctant to offer higher bandings to staff and there were not always vacancies for people with enhanced practice skills to use those skills and therefore be paid at the higher grade.

The management team had met to discuss staff retention. They were considering ways to retain staff however were reluctant to increase staff grades in plain film x-ray without staff taking on additional roles, as some trusts nationwide had done.

The department employed some reporting radiographers who spent some of their time carrying out examinations and sometime reporting on x-rays and other scans.

Staff in ultrasound had enhanced training and were able to interpret their own scans and carry out procedures.

Staff told us that radiographers tended to join the trust straight from university, stay for two to three years and then move to another trust at a higher grade. The trust was aware of this issue and managers told us they over recruited from universities as a way of managing this turnover.

**Sickness rates**

The trust has a sickness target of 4.7%. Within diagnostics, the trust reported sickness rates for nursing staff at Diana Princess of Wales Hospital only. The rate was 0% which met the trust target.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>0</td>
<td>1294.4</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

Information for allied health professionals showed a rate of less than 4% across all modalities and as low as less than 1% in general radiology.

**Bank and agency staff usage**

Information on bank and agency staff usage provided by the trust does not include nursing staff working in diagnostics.

*(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)*

We requested information about bank and agency use for AHPs. Between April 2017 and March 2018, 1435 shifts were covered by locum radiographers across both sites at a total cost of £512,368. These shifts were both day and night shifts, weekends and bank holidays at predominantly band six and band seven.

**Medical staffing**

The trust reported their medical and dental staff numbers as below, as of January 2018 and January 2017.
Medical staffing rates Diana, Princess of Wales Hospital were 55% in January 2018, the staffing rate was higher than the previous year at this site.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

We requested the Radiology Benchmarking Dashboard Report of the trust. This was for the 2016/2017 outturn position. Of all the trusts who submitted data, this trust had the highest consultant radiologist vacancy rate.

The trust had significant problems recruiting radiologists despite actively trying to recruit both within the UK and internationally however visa regulations had hampered progress. The trust continued to try to recruit as a continuous process.

The trust was working with local trusts’ medical schools and hoped to encourage registrar radiologists to come to the trust in training posts however at the time of the inspection this had not yet materialised.

At the time of the inspection, the department was outsourcing some of its routine and straightforward reporting to two external companies. If urgent advice or reporting was required out of hours, staff accessed one of the outsourced companies. However, a number of trust radiologists also had reporting stations at home and could read x-rays and scans from home if a report was needed urgently.

The trust told us that approximately 25% of CT and 16% of MRI scans were currently outsourced to other organisations for reporting at the time of our inspection.

The trust had an induction programme in place for new medical staff and there was a local induction programme within radiology.

Vacancy rates

Diana Princess of Wales Hospital had a vacancy rate target of 6.28%. The vacancy rate at the time of inspection was 50.4%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The trust was actively trying to recruit new staff to radiologist posts and had attempted recruitment internationally however due to several factors including immigration restrictions, the trust had limited success. However, recruitment was an ongoing process.

The trust was working with local trusts medical schools and hoped to encourage registrar radiologists to come to the trust in training posts however at the time of the inspection this had
not yet materialised.

**Turnover rates**

Turnover rates data provided by the trust do not include information on medical staff assigned to diagnostics.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Sickness rates data provided by the trust do not include medical staff working in diagnostics.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

In diagnostics, from February 2017 to January 2018, a total of 253 shifts (94%) were filled by locum staff. There were 15 shifts (6%) that remained unfilled. Of these shifts, 118 were at DPOW.

The bank and locum staff usage within diagnostics broken down by site is shown below:

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0 (0%)</td>
<td>253 (94%)</td>
<td>15 (6%)</td>
<td>268</td>
</tr>
</tbody>
</table>

Diana, Princess of Wales Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0 (0%)</td>
<td>118 (100%)</td>
<td>0 (0%)</td>
<td>118</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Records**

The department used electronic records and digital images accessible to all appropriate staff for viewing. Reports were available digitally and were part of the electronic patient record.

We looked at the record keeping system used in the department. It was linked to the patient’s main records and the Accident and Emergency department records system. The system made sure all relevant fields of information were completed and that results were easily accessible to relevant personnel.

Staff could check the A&E system to make sure any anomalies on x-rays or scans had been picked up by the medical staff in A&E who would look at the image before a reporting radiographer or radiologist would. This was particularly helpful when images were difficult to read, or anomalies were small. There was an additional system in place to ensure that once an image had been reported by the radiology team, the A&E department were notified of any potential missed diagnoses such as minor fractures.

X-ray results were emailed or posted to GPs automatically however the timeliness of this was
dependent upon how quickly the x-ray or scan was reported. Reporting times were a KPI of the trust and were consistently monitored and reported upon to senior management.

**Medicines**

We checked the storage of medicines across the diagnostic and radiology departments at DPOW. We found medication was stored safely and securely and was regularly checked to make sure no medicines were out of date. Medicines were stored above floor level in locked rooms with restricted access.

We spot checked some medicines and found these were all in date.

The scanning department used medicines such as contrast media for some patients. Staff were aware of the side effects and contra indications and carried out checks with patients to ensure their safety.

Pain relief and sedation were available for patients, prescribed and administered by qualified staff in line with departmental policies and procedures.

The department did not store or use controlled drugs.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events for diagnostics.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in diagnostics which met the reporting criteria set by NHS England from March 2017 to February 2018.

The incident was classified ‘Diagnostic incident including delay meeting SI criteria (including failure to act on test results) and occurred in September 2017.

*(Source: Strategic Executive Information System (STEIS))*

We spoke with staff about incidents. They could describe to us the process for reporting incidents electronically. They understood the type of occurrences they must report, relating to radioactive materials, public and patient safety and staff safety.

We had some concerns that there may have been undetected and therefore reported serious incidents because the department had not undertaken a review of patients whose diagnosis or treatment had been delayed due to delays in reporting.

Staff told us that if they reported an incident, they received an acknowledgement and sometimes feedback depending on the severity of the incident.
The diagnostics and radiology department across the trust produced a regular newsletter where incidents, complaints and concerns were highlighted along with any changes to practice. The newsletter was also used as a method of communicating any external safety alerts to staff. These alerts were also emailed to staff and discussed at team meetings. Team meetings were minuted and minutes sent to staff for information.

Staff understood the principles of duty of candour, being open and honest and told us that if they made a mistake, such as an incorrect x-ray, they would inform the patient and then report it as an incident. Duty of candour was used in diagnostic services across the trust, four times from February 2017 to January 2018. The information was not broken down by site.

Is the service effective?

Evidence-based care and treatment

The trust followed national and local guidance in the treatment of patients. For example, NICE (National institute of health and social care excellence) guidance for stroke patients.

Guidance was available on the intranet for all staff to refer to if they were unsure. Staff told us they followed best practice, guidelines, policies and procedures. However, due to lack of clinical audit we could not be fully assured that staff were following best practice and clinical guidelines.

Patients were given advice about action to take if their condition deteriorated and there were advice leaflets for patients about specific conditions and procedures. We looked at these and some needed to be reviewed.

Patients were protected from discrimination because appointments were allocated purely on clinical need.

Nutrition and hydration

The departments had water fountains available for patients to access cold water.

There were café facilities and shops selling food and drinks within the hospital which patients and relatives could access.

If staff had concerns about a patient who had not eaten and had a health condition such as diabetes, they could provide a light snack, however staff told us this almost never happened as patients usually came prepared.

Pain relief

The departments generally did not administer pain relief for patients. Patients brought to the department as inpatients or from A&E had usually received pain relief before being brought to the department.

Patients having invasive procedures such as biopsies were given local anaesthetic and pain relief, prescribed and administered by qualified staff.

Staff asked patients about their pain levels and tried to ensure any scanning was carried out in the least painful way.

Patient outcomes

We discussed discrepancy meetings with staff and the manager. They told us that discrepancies
were discussed with staff and meetings held at least bimonthly in line with the Royal College of Radiologists guidance.

If there were particular concerns about the performance of individual staff, these were addressed by the manager with the individual.

The trust employed an ISAS (imaging services accreditation scheme) assessor however they were not currently in a position to apply for accreditation due to trust wide staff shortages and reporting delays. However, the trust was aware of the ISAS requirements and working towards them.

We asked the trust for evidence of ongoing clinical audit within diagnostic services. Evidence sent to us showed that the last clinical audit was undertaken in 2017/2018 and related to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). There was no clinical audit related to radiology scheduled for 2018/2019. However, after the initial report was written, the trust sent us evidence to show some clinical audit was being carried out by radiologists.

We requested the Radiology Benchmarking Dashboard Report of the trust. This was for the 2016/2017 outturn position. The report showed that the trust had fewer than the average CT scanners per 100,000 patients and fewer that the average MRI scanners per 100,000 patients. This corroborated what the trust was already aware of, that they needed more scanners to meet ever increasing demand.

Demand on the department had continued to grow in each modality other than PET scanning over the past five years and the trust had one of the highest levels of CT scans per 100,000 bed days in the country.

The trust had a rate of 2100 examinations per WTE staff. This was more than the average and showed that staff at the trust were examining more patients than colleagues at other trusts.

Of the trusts who submitted data, this trust was seventh in the list of highest outsourcing trusts with 7% compared to an average of 4%. The highest trust had an outsourcing rate of 26%.

This trust could not meet the reporting demands of the examinations it carried out. There was an impact on patients because patients had to wait longer for the results of their scans and there was a risk that this could have a detrimental impact on their health, treatment and recovery.

**Competent staff**

**Appraisal rates**

From April 2017 to January 2018 85% of staff reported by the trust to be working in diagnostics at the trust had received an appraisal compared to a trust target of 95%.

A split by site and staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Appraisal Completion</th>
<th>Trust Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>
Diana, Princess of Wales Hospital had an appraisal completion rate of 84.4% for diagnostics with only nursing staff meeting the 95% appraisal completion target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff we spoke with at DPOW told us their managers was good at making sure they had appraisals and general support within their roles.

Staff said annual appraisals were supportive and worthwhile.

Staff had received training in supporting patients with dementia and challenging behaviour although they were currently not meeting the trust 85% standard for these. Patients with these conditions could be supported in the department. Staff told us they could ask for additional support if it was required.

The department at DPOW used bank and agency staff. Staff worked extra hours when they could to cover shifts however, locum staff were used. There was a local induction in place to ensure staff were orientated with the department and familiar with where supplies and equipment were stored. Locum staff could access IT systems as required.

All staff had undergone training to identify if patients were deteriorating and how to access further support for the patient if required.

### Multidisciplinary working

The departments at DPOW worked with the outpatient’s department and specialties to provide x-rays and scanning services for patients.

There were several multidisciplinary (MDT) clinics run across the DPOW site. These included a respiratory clinic where spirometry (breathing) test were carried out on the same day and reported prior to the patient seeing their consultant, a vascular clinic run in conjunction with vascular surgeons from another trust, where ultra-sound was available, a transient ischemic attack (TIA or mini stroke) clinic with carotid artery scanning and a hysteroscopy and urology clinic. The trust was also in the process of setting up a neurophysiology clinic with a neighbouring trust using diagnostic and radiology processes as support. MDT clinics meant better care and treatment for patients as diagnostic tests were carried out and results available to clinicians in a timely way.

Radiologists worked on site at DPOW, however they could report on films from any location that had a reporting station.

Radiologist on site at DPOW also carried out clinical interventions with patients using radiological guidance such as biopsies, injections and placement of stents. These interventions involved
working with specialties and staff from other disciplines.

Radiologists attended multidisciplinary meetings about patients held on the other two sites. These meetings discussed patient diagnoses and treatment options with specialists such as surgeons and oncologists.

**Seven-day services**

The general radiology department at DPOW could deliver x-rays 24 hours a day and used an on-call system over night.

The scanning department was open from 7am until 10.30pm every day to carry out scans. Overnight on call cover was in place to ensure that any urgent scans such as CTs for possible stroke patients were carried out quickly and within national guidelines.

The department had a visiting CT scanner and a visiting MRI scanner on certain days during the week to enable extra capacity for scanning and to carry out scans on patient torso that the current scanner was unable to do due to lack of quality of images.

**Health promotion**

The departments had posters and leaflets to promote patient good health, such as about stopping smoking, healthy diet, child and adult safeguarding, domestic violence and promoting screening for health conditions such as cancers.

We asked staff if they spoke with patients about promoting good health. They told us they would only intervene if the patient asked for advice or if they thought the patient was in immediate danger or harm such as from domestic violence.

Staff in the Pink Rose suite offered health advice to patients to support them in their diagnosis and through their treatment.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff in the department had completed Mental Capacity training. The compliance rate was 73% therefore the trust target of 85% was not being met at DPOW.

Some staff were required to attend Deprivation of Liberty training. The compliance rate for this training was 100% for DPOW.

We spoke with staff about obtaining consent form patients who had learning difficulties or were living with dementia. They told us if the patient was unable to identify themselves they would not perform the examination. If the patient was an inpatient, and the patient couldn’t give consent they told us they would expect to see information about a best interest decision. A best interest decision is a decision made on behalf of a patient by clinicians when the patient is unable to make that decision themselves.

The service at DPOW provided plain film x-rays, ultrasound, CT, MRI and a number of invasive procedures such as biopsies. Some of these procedures required written consent from patients.

Staff involved in procedures where consent was needed told us consent was sometimes taken on the ward (if the patient was an inpatient) and sometimes in the department. Staff knew their responsibilities to explain procedures, possible side effects and what might go wrong during procedures and make sure the patient was able to understand the information they were told.
before taking consent.

For plain film x-rays, verbal consent was obtained from patients. The process included staff informing patients of the risks of having an x-ray and the contraindication of x-raying when patients had some conditions or were pregnant.

When a patient was pregnant or suspected they were, staff discussed the risk of an x-ray on the unborn child and supported patients to make a decision. Staff also offered patients the option of lead apron protection of the abdomen in cases when an x-ray was necessary.

Inpatients who required an x-ray had their identity checked from their wrist band and against the x-ray referral. The staff did not formally document consent but used implied consent.

Is the service caring?

Compassionate care
We spoke with nine patients and relatives during our inspection of the DPOW radiology and diagnostics sites.

All the patients we spoke with told us they had been treated with courtesy and respect. Patients told us they had their dignity preserved as they were treated and staff made sure they were covered and not left exposed.

We observed staff interact with patients of different ages and with different health conditions such as dementia. Staff were kind, patient and caring with patients as they supported them on and off beds, out of wheelchairs and on to scanning and x-ray apparatus.

Emotional support
Staff provided patients with emotional support during their attendance at the departments if it was needed.

Anxious patients were not rushed and were given time to get used to the environment. For example, patients worried about having a CT or MRI scan could visit the department prior to their appointment to look and the scanner and have staff explain exactly what would happen during the scan.

Staff also supported patients with further advice and support, such as in the Pink Rose suite where patients were attending for breast care. They spent time with patients discussing procedures, diagnosis and future options with patients.

Staff could refer patients for additional counselling and support if this was needed.

Understanding and involvement of patients and those close to them
The patients we spoke with told us staff explained to them why they were there and what would happen during the x-ray, scan or procedure they were having.

Patients and relatives were given time to ask questions about their treatment such as any side effects or complications they might experience.

Staff made sure relatives and carers could be with the patient if this was what the patient requested, if it was safe to do so, such as vulnerable patients undergoing x-rays.
Patients told us staff explained information in a way that was easy to understand and did not contain lots of medical jargon or terminology. This made sure that when patients were being asked to give consent, they fully understood what they were consenting to and the associated risks.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The various diagnostic and imaging departments on the DPOW site were all located on the ground floor of the hospital on a single storey with wide doors therefore it was easy for patients and relatives to access. They were well signposted and easy to find.

Car parking on site was difficult as there was a lot of demand for parking spaces.

There were some toys to keep children amused while they were waiting.

The general radiology department was open 24 hours a day however, overnight, service was limited to urgent and emergency activity. Staffing was reduced with two radiographers and a health care assistant on duty to treat patients.

The scanning department began scanning at 7am and finished scanning patients at 10pm seven days a week to try to meet demand. Emergency overnight scans were carried out by a team of on call radiographers with health care assistant support.

We asked staff about long waits in the departments. They told us that patients did sometimes have long waits, especially if another patient needed to be seen as an emergency. Although waiting lists were designed to allow some capacity for urgent and emergency appointments throughout the day, because of the unpredictability of emergency demand, there were times when routine patients experienced delays.

Staff told us they tried to keep patients informed of delays both when they checked in and throughout their wait if the situation changed.

**Meeting people’s individual needs**

The department provided information for patients about treatments offered by the radiology department. These were also online for patients to access. We checked all the leaflets and found that seven had passed their review date. Additionally, there was no information about how to access the leaflets in other formats such as large print, Braille, easy read or other languages.

Staff told us they could access interpreters either in person or by telephone if needed however during our inspection we did not see any patients who needed interpreters.

The department could accommodate bariatric patients for x-rays if required and the waiting area had a larger seat. Bariatric patients requiring some scans such as MRI or CT could not be accommodated on site and were referred to a different scanning provider with an open sided scanner.

Patients with claustrophobia or worries about scans could attend the department to look at the scanner and have the process explained to them before their appointment. The aim of this was to put the patient at ease but also to reduce the number of abandoned procedures. Patients who still felt they could not cope with being inside the scanner tunnel, or the noise of the scan could be offered an appointment to attend an open sided scanner or offered sedation.

There was no specific quiet area for patients with sensory needs or who did not like to be in busy
areas due to health conditions in the general x-ray department however, we asked staff how they would support such patients and they told us patients would be supported to be seen quickly if they were becoming unsettled. There were no such patients in the departments during our inspection so we were unable to test this out.

Within the scanning department, the environment was generally smaller and less noisy for patients. Staff in this department also told us they would support patients to be seen quickly. The Pink Rose suite supported patients in a quieter environment tailored to maintaining privacy and dignity.

**Access and flow**

**Diagnostic waiting times (percent waiting 6+ weeks)**

From June 2017 to January 2018, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average, following an upward trend over the period. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England.

![Graph showing diagnostic waiting times](image)

(Source: NHS England – Diagnostic Waits)

Patients had long waits to have their examinations reported upon. The trust had a backlog of reporting due to the shortage of radiologists in the department. At the time of our inspection, the backlog for each modality trust wide was as follows:

- Plain film x-rays, 1805 report backlog, longest report delayed by five weeks.
- CT, 551 report backlogs, longest report delayed by seven weeks.
- MRI, 353 report backlogs, longest report delayed by 10 weeks.
- Ultrasound, 12 report backlogs, longest report delayed by two days.

For general radiology there was a backlog of 1119 unreported films.

We discussed inpatient demand with managers in the trust. They told us that inpatient referrals were given priority, particularly from A&E, then the wards. Priority was then given to two-week urgent referrals, urgent referrals and then routine referrals.
We asked staff how scan referrals were prioritised. Staff told us decisions were made by administrative and radiography staff using specific criteria however radiologists were also consulted to make sure no urgent referrals were missed. This process was used across the trust.

The management team at DPOW monitored performance against local and national key performance indicators (KPIs). We requested evidence of this and the trust provided us with the monthly position statement for each site and modality. The statement was comprehensive and monitored waiting times, reporting times, staffing levels, locum and bank use, a financial summary, did not attend (DNA) rates, number of referrals, demand and activity increases and any exceptional events to note. The statement was discussed within the senior management team to ensure they were aware of any concerns or problems the department was encountering.

Managers told us that demand on radiological services was increasing significantly year on year leading to pressure on all radiology services although particularly MRI and CT. There was additional pressure at DPOW because of equipment breakdowns and unreliability.

When patients DNA, the department offered one further appointment, however DNA added pressure to services. The combined DNA rate for DPOW was 4.9% for CT scans and 4.6% for MRI scans.

In March 2018, the routine waiting time for the Ultrasound department was up to six weeks and 95% of patients on the 31/62 day pathways were being seen within 14 days.

In March 2018 DPOW saw 73% of CT and 74% of 31/62 day wait MRI patients within 14 days. This was highlighted in red as missing the trust target.

The trust had encountered problems with mechanical breakdowns of both MRI and CT scanners and the risk register showed that some scanners were classed as ‘end of life’. This meant that the manufacturer no longer made spare parts. When the machinery broke down, new spare parts were not always available and the trust needed to use recycled spare parts that did not always have a long life either.

Over the six months from November 2017 to April 2018 the following breakdowns to scanners had occurred at DPOW:

- CT, 107.5 slots and 94 hours of scanning time
- MRI, 116 slots and 89 hours of scanning time

Staff told us patients in the department sometimes had to wait because procedures were more complicated and sometimes needed preparation, such as injection of contrast media or other medication before they could have their scans.

Within the general radiology department, some patients experienced delays if their attendance was unplanned. This had an impact on planned patients in the department. If there was a delay, staff informed patients how long this was likely to be either when then checked in, or if the situation changed.

**Learning from complaints and concerns**

**Summary of complaints**

From 7 February 2017 to 7 February 2018 there were nine complaints about diagnostics, all for radiology. The trust took an average of 55 working days to investigate and close these complaints.
The trust has a target to close complaints within 30 working days and a further target of 45 working days. Only two of the nine complaints in diagnostics were closed within 30 working days and with four closed within 45 working days.

The trust has a target to close more complex complaints within 60 working days. Five of the nine complaints (complex and non-complex) were closed within this target.

The most common subjects complained about in diagnostics services were patient care (five complaints), appointments (two complaints) and communications and admissions/discharges with one complaint each.

Diana, Princess of Wales Hospital

There were six complaints about diagnostics at this site, taking an average of 74 days to complete. Of these, five complaints were for patient care.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Summary of compliments

From 7 February 2017 to 7 February 2018 the trust received 30 compliments for diagnostics.

Diana, Princess of Wales Hospital

There were 22 compliments for:

Endoscopy – eight compliments received
Medical Physics – five received
Radiology – four received
Diagnostic Investigation Unit – three received
Pathology – two received

There was information in the waiting rooms informing patient about how to make a complaint or pass on a compliment to staff in a formal way. Patients were encouraged to give feedback to improve the service provided.

Lessons learned were fed back to staff on a regular basis at team meetings and via a radiology newsletter that also contained information about incidents, new policies and procedures, changes and advances in practice and interesting information about the department trust-wide. Staff at DPOW had to sign to say they had read and understood the newsletter contents.

Is the service well-led?

Leadership

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 clinical director and directorate general manager. Clinical support services also had a business manager and two business support managers.

Each modality had a service manager who oversaw the day to day functions of the department. We met with most of these staff during our inspection. Modality managers were aware of the challenges facing the department and the KPIs they were required to meet. They understood the challenges in relation to performance, demand, staffing and risks.
Staff we spoke with during the inspection at DPOW told us that they felt well-led at a local level and they had no concerns with their line manager. They told us managers were approachable and supportive. Staff gave examples of how managers showed their appreciation to staff for their hard work and recognised that staff were patient focussed and dedicated to helping their patients. One member of staff told us that if it wasn’t for their line manager they would have gone to work at another trust at a higher grade.

Staff we spoke with knew who the new chief executive was and felt that the trust had changed in a positive way since our last inspection.

**Vision and strategy**

We interviewed the management team during the inspection. They were aware of the pressures at DPOW, the condition of the equipment, the staffing turnover and recruitment and retention issues and the increasing demand for more complex scans and interventions.

Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to try to manage demand however current resources in the department were increasingly stretched.

The management team had a strategy for diagnostic and radiology services. The team spoke about this at our last inspection in October 2016 however, progress with the strategy was not as advanced as the management team had hoped it would be.

In October 2016 the team spoke about future proofing the departments across the trust, purchasing new and additional equipment, recruiting more staff and succession planning however at this inspection we found that these visions had not come to fruition with medical staffing shortages, increased demand on equipment and longer waiting and reporting times than at our previous inspection.

**Culture**

We found there was good collaborative working between staff at DPOW.

Staff we spoke with told us it was a “positive culture” with good teamwork. They said there were no problems escalating any concerns or worries at DPOW to line managers however, some staff felt that the more senior management team could be dismissive of their concerns. Some staff also felt as though the work they did was not always appreciated by senior leaders in the department and they were undervalued.

The team at DPOW was often changing due to new staff joining and current staff leaving however staff told us the team worked well together and pulled together during difficult and pressured times to support each other. Newer staff told us that they felt supported by more experienced colleagues.

The departments were patient focussed and staff worked together to make sure patients had a good experience.

Staff spoke positively about the service they provided for patients and were aware of the importance of providing a quality service with a positive patient experience.

**Governance**
Governance arrangements were in place within radiology. The clinical support services (CSS) division held monthly meetings where performance and governance were discussed. Information from these meetings was shared with front line staff both in person and via email minutes.

The department held medical exposures committee meetings and radiation protection committee meetings. These were recorded and shared with relevant staff.

The service held monthly team briefing meetings at the DPOW 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 at the team meetings. Comments, compliments, complaints, audits and quality improvement were also discussed. This information was also shared in a regular newsletter which was printed off and kept in the staff break room for staff to read at their convenience. All staff had to sign to say they had read the newsletter.

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 saw examples of this during the inspection as some radiographers showed us their feedback, mostly positive but with some constructive advice.

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.

There were governance processes in place to ensure that externally reported images were scrutinised and managers told us that they had sought assurance from each outsourcing support provider of their governance processes to ensure they were at least as robust as those of the trust. The trust was assured that there were robust governance processes in place.

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 a service level agreement was in place. The RPS was a radiographer based within the trust.

Management of risk, issues and performance

The hospital had a risk register in place and managers updated this accordingly. Managers were aware of the risks within their departments and were trying to manage them.

There were 11 risks on the risk register for DPOW relating to radiology, diagnostics and imaging. One related to an ultrasound machine in the Pink Rose suite that should have been replaced a year ago and was showing advisories, two related to CT equipment either needing to be replaced, or not functioning correctly, two related to general x-ray both relating to equipment either needing to be replaced or potentially not having enough equipment, one related to MRI image quality and lack of body scanning for immobile patients on DPOW site. The remaining risks related to either lack of equipment or equipment coming to its ‘end of life’. Although the department was hiring equipment to meet additional demand, we still had concerns about scanning provision in an emergency if equipment broke down.

Of the 11 risks, three had a high risk rating, three had a moderate risk rating and four had a low risk rating and one had no risk rating recorded.

There were also risks in diagnostics and radiology that were classified as trust wide. There were five risks noted. Two were classified as high risk, two were classified as moderate risk and one was classified as low risk. One risk had not been classified. The risks related to workforce, meeting patient pathway targets and replacement of equipment.
Risks on the register had a clear owner and evidence of action and updates.

We had concerns that the trust had not completed a review of patients for assurance about the length of time some patients were waiting for test results and

**Information management**

The department collected information used to monitor and manage performance. There were measures in place to monitor and manage the performance of the department against local and national indicators. These were observed by the management team.

The department used several IT systems to collect and share information such as x-ray and scan results.

Staff could access patient information using an electronic system. This included information such as previous x-rays and scans.

Some information such as scan and x-ray reports were shared with GPs however this was done with the agreement of patients.

The trust had information governance policies and procedures in place to ensure that information was stored securely and protected patients’ privacy and security.

Staff were aware of their responsibilities in relation to data protection and making sure that information was accurate and managed securely. Data protection principles were followed within the department at DPOW.

Information governance including data protection and confidentiality was monitored and any incidents reported appropriately.

**Engagement**

The trust did not supply us with any evidence to demonstrate engagement with patients who used the diagnostic and radiology services at DPOW prior to our inspection however subsequently sent evidence to demonstrate that inpatient and outpatient satisfaction surveys were carried out annually.

The trust had begun to work with staff across the staff to look at culture, engagement and equality and diversity across the trust. Staff at DPOW were part of this engagement.

**Learning, continuous improvement and innovation**

DPOW offered a radiographer led salpingography ultrasound service, the first in the country.

Staff told us they could access training that was related to their role however some staff felt frustrated at not being able to progress within the department and achieve promotion within plain film radiology. This was common across all three sites at the trust.
Goole – Acute services

Medical care (including older people’s care)

Facts and data about this service

Northern Lincolnshire and Goole NHS Foundation Trust provides a range of medical services for patients at all three of the acute hospital sites:

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

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

Admissions for the top three medical specialties were:

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

(Source: Hospital Episode Statistics)

The Trust provides comprehensive acute and non-acute medical services at Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPOW) at Grimsby, on an in-patient and outpatient basis. Outpatient services and sub-acute inpatient beds are provided at Goole District Hospital (GDH). The trust took over the provision of the neuro rehabilitation centre at GDH in September 2017.

There are 419 medical inpatient beds located across all three sites, 29 of these were at GDH.

A medical service breakdown for GDH can be found below:

Goole and District Hospital:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 3</td>
<td>General Medicine</td>
<td>15</td>
</tr>
<tr>
<td>NRC - Ward 4</td>
<td>Specialist Neuro Rehabilitation Centre</td>
<td>14</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>Currently closed</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request - Acute-Sites)

Is the service safe?
**Mandatory training**

**Medical/Dental Staff**

At this inspection we found that compliance with mandatory training was poor for medical and dental staff. None of the modules at any of the hospitals achieved 85% compliance. Overall compliance was worse at SGH and compliance rates with most modules were very poor. Disaggregated data was not available for GDH; this was collected as part of SGH data. Medical staff we spoke to however, told us that they were up to date with their training and had not had a problem accessing this. Junior doctors we spoke with told us they had received an induction and were up to date with their mandatory training. Locum staff we spoke with told us their mandatory training was provided by their employing agency and that the trust did not provide this for them.

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for medical/dental in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>66</td>
<td>100</td>
<td>66%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>59</td>
<td>100</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>55</td>
<td>100</td>
<td>55%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>48</td>
<td>98</td>
<td>49%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>47</td>
<td>96</td>
<td>49%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>46</td>
<td>99</td>
<td>46%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>44</td>
<td>100</td>
<td>44%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>39</td>
<td>100</td>
<td>39%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>32</td>
<td>100</td>
<td>32%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>30</td>
<td>100</td>
<td>30%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Goole District Hospital**

The trust did not provide any training data for medical/dental staff at Goole.

**Nursing Staff**

We found that compliance with mandatory training for nursing staff was 82% overall, an improvement on 2016 which was 77% overall. The target of 85% completion was reached in six out of 10 modules across the trust but only in five out of 10 modules at GDH. The lowest completion rate for any module at GDH was 71%.

Nursing staff we spoke with told they were up to date with their mandatory training and ward managers and matrons told us that there was sometimes a delay with training completion and the electronic system being updated.

During inspection, managers showed us records which indicated that the overall compliance rate for mandatory training for nursing, therapies and support worker staff at the Neuro Rehabilitation Centre (NRC) was 68% in April 2018. Managers explained the NRC rate was for trust training completed by staff in the eight months since the service became part of the trust in September 2017. Trust staff had worked with the NRC to develop a bespoke training matrix for the team, when they became part of the trust.
A breakdown of compliance for mandatory courses for nursing staff in medicine from February 2017 to January 2018 is shown below:

### Trust level

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>377</td>
<td>404</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>374</td>
<td>404</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>348</td>
<td>404</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>336</td>
<td>400</td>
<td>84%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>335</td>
<td>404</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>329</td>
<td>402</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>315</td>
<td>404</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>311</td>
<td>400</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>304</td>
<td>404</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>292</td>
<td>404</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(From: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

### Goole District Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>13</td>
<td>14</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>12</td>
<td>14</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>12</td>
<td>14</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>12</td>
<td>14</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>12</td>
<td>14</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>11</td>
<td>14</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>11</td>
<td>14</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>10</td>
<td>14</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>10</td>
<td>14</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>10</td>
<td>14</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(From: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

For new starters, most mandatory training was delivered through a two week ‘care camp’. There was an induction booklet for staff to use with agency staff and we saw this was in use on ward 3.

### Safeguarding

The Chief Nurse was the executive lead for Safeguarding within the organisation and an operational Head of Safeguarding who was the strategic lead and manager of the Safeguarding team. The trust had three safeguarding forums for Children, Adults and PREVENT, which reported into the Quality and Safety committee a subcommittee of the Board. The head of the safeguarding team reported directly to the trust’s chief nurse. (Source RPIR January 2018)

There were no safeguarding referrals from the medical wards at GDH from February 2017 to January 2018.
The trust had safeguarding policies available to support staff; these could be accessed on the trust intranet.

Staff were aware of their responsibilities and how to contact the trust safeguarding team for advice. Staff on ward 3 described examples of reporting a concern and using a best interest decision to safeguard a patient. Managers told us NRC staff had recently completed a bespoke safeguarding training session delivered at GDH and worked closely with trust safeguarding leads.

The trust set a target of 85% for completion of safeguarding training. For the trust overall, medical staff compliance was between 72% and 75% for the different modules. Data for GDH was part of that reported for SGH which had the lowest compliance for medical staff between 62% and 64%. Trust overall compliance for nursing staff was better at around the target of 85% and compliance at GDH was 79% compliance for safeguarding adults training and level 1 safeguarding children training. Compliance for level 2 safeguarding children training was 71%

**Medical / Dental Staff**

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical/dental staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>75</td>
<td>100</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>74</td>
<td>100</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>72</td>
<td>100</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Goole District Hospital**

The trust did not provide any training data for medical/dental staff at GDH.

**Nursing Staff**

A breakdown of compliance for safeguarding courses for nursing staff in medicine over the same period is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>349</td>
<td>404</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>349</td>
<td>404</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>337</td>
<td>404</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Goole District Hospital**
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>11</td>
<td>14</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>11</td>
<td>14</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>10</td>
<td>14</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

At GDH, managers showed data which indicated that completion rates for safeguarding adults training were 90% for staff at the Neuro Rehabilitation Centre (NRC) at April 2018. 87% of NRC staff had also completed safeguarding children training at level one. Managers explained the NRC rate was for trust training completed by staff in the eight months since the service became part of the trust in September 2017.

Cleanliness, infection control and hygiene

We found wards and departments to be visibly clean and tidy. During inspection, we observed staff cleaning their hands between patient contacts. Hand gel dispensers were available on the wards, although there were no gels in the dirty utility or near the kitchen on ward 3. Personal protective equipment (PPE) was available and staff were using it appropriately.

We saw green ‘I am clean’ stickers used on both wards to identify a range of equipment was clean to use, for example walking aids, moving and handling equipment and blood pressure monitors. We saw cleaning schedules completed and displayed and we saw information about preventing blood stream infection displayed on both wards.

There were systems in place for organising cleaning materials and equipment and for waste disposal, although we also noted that the dirty utility room where containers of disinfectant were stored was not locked, which could present a hazard to patients on ward 3.

Staff told us they could access support from an infection control nurse seven days per week.

Staff completed infection prevention and control training; compliance for nursing staff across the medical service at trust level was 75% and 71% at GDH, below the 85% target. Medical staff compliance with this training was very poor 32% across the trust, data for GDH medical staff was not disaggregated from SGH which was 29% compliance. (See mandatory training breakdown above)

We saw there were monthly infection control audits, across the trust medical wards, carried out by ward staff, matrons and infection prevention and control nurses (IPCNs) who looked at ten indicators which included cleanliness of the environment and equipment, hand hygiene facilities, disposal of waste including sharps and clinical practice. From April 2017 to March 2018 overall compliance with the range of indicators ranged between 76% and 97%. Scores given by the IPCNs tended to be lower than those awarded by the ward staff. Compliance was mostly above 95% for hand hygiene facilities and clinical practice over the year and never fell below 85%. Compliance was more variable for cleanliness of general environment, patient equipment, storage areas, waste and linen disposal and sharps safety. Following inspection, the trust provided completed audit scores for wards at Goole. These showed that Ward 3 met the trust target of 95%, scoring between 96% and 100% in each recorded audits from April 2017 to April 2018. For the same period, the NRC scored between 77% and 100% for the same period.

Environment and equipment
The trust provided the results of the August 2017 patient led assessment of the care environment (PLACE) assessment. Patients gave this trust an overall score of 98% for cleanliness. This was the same as the national average.

From April 2017 to March 2018 general environment audit compliance, at trust level, was consistently the worst performance of all the infection control indicators and only scored over 90% on two occasions out of twelve, at least one of the auditors scored this indicator below 85% (red rated) every month. The trust did not provide a breakdown by hospital site or ward so we were not assured this audit had included GDH wards.

We saw that resuscitation equipment was available on Ward 3 and on the Neuro Rehabilitation Centre (NRC) at GDH, although the trust process for daily checking and restocking was not yet fully embedded at the NRC. The NRC trolley was kept in the meeting room, which was kept unlocked and accessible. However, on the unannounced inspection, we saw that the NRC trolley was not restocked after use and had not been checked for the two previous days. We saw that although weekly checks had been completed since October, daily checks had been missed on 11 days in April. During inspection, we also noted that resuscitation trolley on ward 3 was not routinely secured with a numbered tag, for tracking purposes. The resuscitation trolley was equipped with appropriate equipment, including a defibrillator.

We saw ward 3 had a therapy gym and the NRC had a private garden area and a therapy kitchen to support patients in their recovery. However, staff told us that the therapy kitchen had been closed since November 2017. Managers explained this was because a separate handwashing sink was required to comply with environmental health requirements. During our unannounced visit, we saw a new handwashing sink was installed. Managers told us they planned to re-open the therapy kitchen, once a new environmental health inspection was completed.

The NRC accommodated patients in single or shared ensuite rooms, which was important when people may stay on the unit for extended periods of time.

We noted Ward 3 stored some equipment such as hoists in a small corridor which partially blocked a door to the gym and its position outside the toilets and could present a hazard to patients with a mobility difficulty.

Both ward 3 and NRC staff had identified issues with broken doors and problems with the call bell system. Staff were mitigating this, for example by using walkie talkies or a traditional hand bell in the patient lounge. Managers had escalated these issues via the trust estates and facilities team and had a date for remedial work to be carried out and a new call bell system to be installed, within the next two months.

Managers told us it could be difficult to control the temperature in different parts of the hospital and that there were ongoing discussions about this, with the trust.

Staff at the NRC told us they could access equipment such as for bariatric (larger) patients, from Scunthorpe hospital, but there could be delays in obtaining funding from clinical commissioning groups (CCGs) for equipment for patients going home; for example, if a specialist hoist was required.

We saw that an equipment tagging system was in place to identify when the next safety test was due and tests were up to date for equipment such as blood pressure monitors and moving and handling equipment.

**Assessing and responding to patient risk**

Managers told us there was no formal inclusion / exclusion criteria in place for the NRC. Many patients had experienced traumatic brain injury although some patients had other conditions.
requiring complex rehabilitation for example, multiple sclerosis or brain tumour.

Before admission, nursing and therapy staff from the unit would go to assess the patient for suitability. Patients were required to be medically stable and not using oxygen, to be admitted to the unit. We saw that two patients were currently away from the unit, in Scunthorpe receiving acute care. Managers told us that the number of patients with a tracheostomy was also limited to three, to ensure appropriate care could be given. We saw that there were three patients with a tracheostomy on our first visit and one on our second.

During inspection we reviewed a sample of patient records. We reviewed medical and nursing notes for 18 patients at GDH. We completed five comprehensive reviews and we checked key assessments for a further 13 patients.

On both wards, records showed staff completed risk assessments to identify and monitor patients’ risks and completed several care rounds during the day. Ward 3 had recently introduced a twice daily safety brief for staff, to highlight key patient risks in detail, including pressure areas, falls and mental capacity.

On the NRC, we saw that some risk assessments were not reviewed weekly, as per trust policy. We saw gaps in the weekly assessments of three patients, where pressure area care risk assessments were only updated after two weeks in each case. We noted some similar gaps in nutrition and hydration assessments.

On the NRC, we also saw that the care bundle observation chart identified two-hourly checks were required for patients with a tracheostomy. For one patient, we saw that several of these checks had been missed or not recorded on several days. On some days, up to three checks had been missed, sometimes at night. This meant there was a risk that patients with breathing difficulties were not routinely checked. We raised this with the ward manager and the service manager, who were not aware of why the checks had not been completed. Staff told us there had been an emergency relating to a tracheostomy on 22 May 2018.

Managers told us that slips, trips and falls were the most common incident on the NRC unit and we saw an inpatient falls form which staff completed in the event of a fall, to identify any necessary changes. However, we noted that for one patient who had fallen twice, the form was not fully completed following the first fall and we saw no evidence of a form being completed following the second. No changes were identified and it was unclear whether the senior nurse had been informed. This meant there was a risk staff had not responded fully to mitigate potential patient risks.

Staff told us patients at GDH were medically stable but could be transferred to Scunthorpe hospital by ambulance if acute care was required. During inspection, two NRC patients were currently at Scunthorpe hospital receiving acute medical care. There had been a serious incident which was being investigated at the time of inspection, where a patient’s anti-seizure medicines had been missed over several days due to difficulties with a naso-gastric tube, which meant the patient had to be transferred to Scunthorpe hospital from the NRC, following a seizure.

Staff told us there had been three deteriorating patients transferred out from ward 3, since February 2018.

We saw that a detailed handover took place before a patient was transferred to ward 3, this included information about diagnosis, medical history, care needs and latest National Early Warning Score (NEWS) score.

The National Early Warning Score (NEWS) is a tool that is used to alert health care practitioners to deteriorating patients and therefore trigger an escalation of care and review of the unwell patient. Staff used the trust’s electronic patient safety system, WebV, to monitor patients'
National Early Warning Score (NEWS) and notify them when observations were due.

Additional information provided following inspection indicated that compliance with timely observations was extremely poor on both wards. On average, 20.38% of NEWS observations were completed on time at the NRC from December 2017 to June 2018. This ranged from 32.5% in December 2017 to 8.6% in March 2017 and 17.72% in June 2018, indicating no improvement over time. On ward 3 for the same period, 43.3% observations were completed on time. This ranged from 32.9% in December 2017, to 54.6% in June 2018, however there was evidence of some improvement month on month.

Staff told us patients on the NRC with sepsis could either be managed on the ward if medically stable, or if a patient deteriorated, they would be transferred to acute care at Scunthorpe hospital.

The trust also used a nationally recognised sepsis-screening tool. Where applicable, we saw sepsis-screening tools in the notes we reviewed. The trust had achieved around 80% compliance, across the trust, with screening of appropriate acute adult inpatients for SEPSIS in the three months prior to the inspection.

Recording of physiological observations was audited and reported as part of the nursing audit dashboard. However, there was no record on the Nursing Adult Audit Dashboard of any audits being carried out on medical wards at GDH in 2016 or 2017. Audits carried out at the other hospitals were of physiological observations, falls, skin and food and hydration and patient safety indicators.

Staff on the NRC told us that there was an escalation plan in each patient’s notes and that out of hours; they would escalate via the bleep holder / night co-ordinator. Out of hours there was a doctor based on ward 3, who covered both wards. There was also a nurse bleep holder within the ward staff. Staff told us it was sometimes difficult to get medical staff to come and assess a patient and communication could be improved.

Managers told us that the nurse bleep holder out of hours would usually be a senior nurse (band 6 or 7) or a suitably trained band 5 nurse. Staff told us that experienced Band 5 nurses on ward 3 would often act as bleep holder. Managers told us Band 5 nurses on the NRC had not yet completed bleep holder training. However, staff told us some of the Band 5 staff nurses were working as the bleep holder at night. We reviewed the bleep rota during inspection and saw that a Band 5 nurse was allocated to act as bleep holder on two, day shifts. Staff told us that agency nurses would often work on the ward at night and they may be left in charge of the ward if the bleep holder was required to leave the ward.

A recent serious incident had highlighted the importance of senior clinicians and staff with specialist skills in responding effectively to urgent and changing patient needs on the NRC and across the Goole site.

Managers told us that plans for a GDH matron / site manager had recently been approved which would allow for more senior nurse cover at the site.

Nurse staffing

In January 2018 the trust had a qualified nursing staff fill rate of 96.2%, with 12.1 fewer WTE staff in post than the trust planned to provide safe and effective care. All three hospitals reported less staff in place than was planned. For the previous year (January 2017) the trust reported a slightly higher staff fill rate of 97.5%, however the planned whole time equivalent (wte) across the trust had risen as had the actual number of staff in post from 2017 to 2018. GDH had 0.3 wte registered nurse vacancies in January 2018.

The trust reported their qualified nursing staff numbers as below, as of January 2018 and

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>158.4</td>
<td>154.0</td>
<td>152.9</td>
<td>148.8</td>
</tr>
<tr>
<td>Goole District Hospital</td>
<td>13.1</td>
<td>12.8</td>
<td>13.3</td>
<td>12.4</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>145.5</td>
<td>138.2</td>
<td>133.2</td>
<td>130.5</td>
</tr>
<tr>
<td>Total</td>
<td>317.0</td>
<td>304.9</td>
<td>299.3</td>
<td>291.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Planned staffing on ward 3 for the morning shift was: 3 registered nurses and 3 health care assistants (HCAs). Planned staffing for the afternoon shift was: Two registered nurses and two HCAs. Planned staffing at night was: Two registered nurses and one health care HCA. On the day of our inspection, actual staffing met planned staffing levels.

Staff told us that agency staff were often used at night, working with a substantive member of staff, who could also be the emergency bleep holder for the hospital site. Staff told us that supporting an agency nurse and carrying responsibility for the emergency site-wide bleep at the same time could sometimes be stressful. Staff told us that there had been some staff sickness as a result and some staff had refused to be a bleep holder as they felt unsupported.

Planned staffing on the neuro rehabilitation centre (NRC) during the day was: two registered nurses and three rehabilitation support workers (RSWs). Planned staffing at night was two registered nurses and one RSW. Staff often worked a 12-hour shift pattern.

On the day of our announced inspection, planned staffing met actual staffing on the ward. On the day of our unannounced inspection, actual staffing during the day shift was: two registered nurses and two rehabilitation support workers (RSWs), due to sickness and two registered nurses and one support worker for the night shift. To mitigate this and ensure two patients could attend planned appointments at Scunthorpe General Hospital, the ward manager was working clinically in the registered nurse role and the therapies team were working flexibly to allow a therapy assistant (who had previously worked as a RSW), to accompany patients. Managers told us the senior nurse often worked clinically, to provide cover for current vacancies and that staffing the ward could be a challenge when staff were required to escort patients to appointments off-site.

During inspection, we reviewed nursing staffing rosters for the NRC from 26 April to 17 June which indicated that there were two registered nurses covering each night shift in this period, as planned, including at least one substantive member of staff. Staff also told us that therapies staff numbers on the NRC had increased since the service became part of NLaG and there were three therapies assistants within the team.

Average fill rates for the medical wards at Goole hospital from February 2018 to April 2018 are given in the table below; however, there was no data available for the NRC, ward 4. Data for ward 3 shows no fill rates of 87% or above for each of the three months reported. Overfill with care staff was explained by managers as being one of the ways they tried to mitigate for a shortfall of RNs.
<table>
<thead>
<tr>
<th>Ward / unit</th>
<th>Inpatient beds</th>
<th>Date</th>
<th>Registered midwives/nurses</th>
<th>Care staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>01 Feb 2018</td>
<td>97.80% 96.00%</td>
<td>99.40% 96.00%</td>
</tr>
<tr>
<td>Ward 3</td>
<td>15</td>
<td>01 Mar 2018</td>
<td>92.90% 100.10%</td>
<td>97.60% 87.40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Apr 2018</td>
<td>92.70% 90.20%</td>
<td>97.60% 100.30%</td>
</tr>
<tr>
<td>NRC - Ward 4</td>
<td>14</td>
<td>01 Feb 2018</td>
<td>no data available no data available</td>
<td>no data available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Mar 2018</td>
<td>no data available no data available</td>
<td>no data available</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01 Apr 2018</td>
<td>no data available no data available</td>
<td>no data available</td>
</tr>
</tbody>
</table>

A recent report to the strategic development board indicated staffing for the NRC was calculated in line with the acute stroke units and this was bringing the unit closer to the British Society of Rehabilitation Medicine standards for a level 2A/B unit. It was acknowledged this would require continued review depending on the acuity of the patient group and the planned expansion. Managers felt staffing levels ‘remained comparable’ to this standard although a consultant led service must be maintained with adequate junior doctor cover to provide day to day support for complex patients.

**Vacancy, Turnover and Sickness Rates**

NRC managers confirmed there were 2.5 vacancies which had been approved for recruitment. These were for a part-time registered nurse (0.6 wte), a band 6 nurse and a rehabilitation support worker. A band 7 advanced nurse practitioner vacancy had also been advertised.

Ward 3 managers told us there were two whole time equivalent nursing vacancies on the ward and these had recently been advertised for a second time. As recruitment was a challenge, bespoke GDH site recruitment was being considered.

Staff information indicated that there had been an increase in the number of registered nurse vacancies at GDH since the January 2018 data was provided.

From February 2017 to January 2018, the trust reported an annual vacancy rate of 14% for qualified nursing staff in medicine which was higher than the trust target of 6.3%. The vacancy rate at GDH was 12%, lower than SGH at 22% but higher than DPoW at 7%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From February 2017 to January 2018, the trust reported an annual turnover rate of 14% for qualified nursing staff in medicine which was higher than the trust target of 9.4%.

- Diana, Princess of Wales Hospital: 10%
- Scunthorpe General Hospital: 19%
- Goole District Hospital: 15%

None of the hospitals met the trust’s target for turnover rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
NRC managers told us there had been three leavers (two registered nurses) and one rehabilitation support worker, since the NRC joined the trust in September 2017. Managers told us leavers had completed exit interviews and this had highlighted some issues regarding the leadership structure, roles and responsibilities which resulted from a long period where the senior nurse role was vacant, which had since been addressed.

From January 2017 to December 2017, the trust reported an annual sickness rate of 5% for qualified nursing staff in medicine which was higher than the trust’s target of 4.1%. The sickness rates at GDH were much better than the trust target. Sickness rates for the three sites are shown below.

- Diana, Princess of Wales Hospital: 4%
- Scunthorpe General Hospital: 5%
- Goole District Hospital: 1%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Managers on both wards told us there had been some long-term sickness which together with registered nurse vacancies had posed some challenges to the service.

Bank and agency staff usage

From February 2017 to January 2018, the trust reported the following nursing bank and agency staff usage by site:

Trust level

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Assistants</td>
<td>-</td>
<td>4,805 (48.1%)</td>
<td>2,029 (20.3%)</td>
<td>9,987</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>7,907 (40.1%)</td>
<td>4,945 (25.1%)</td>
<td>2,796 (14.2%)</td>
<td>19,737</td>
</tr>
</tbody>
</table>

Goole District Hospital

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Assistants</td>
<td>-</td>
<td>51 (31.9%)</td>
<td>37 (23.1%)</td>
<td>160</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>129 (63.9%)</td>
<td>46 (22.8%)</td>
<td>19 (9.4%)</td>
<td>202</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018 there was a total of 19,737 ‘available shifts’ for qualified nurses (for example unfilled by substantive staff) 40.1% were filled by agency nurses and 25.1% by hospital bank nurses. This means that 14.2% (2,796) of available qualified nursing shifts remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Managers told us it was sometimes difficult to source registered nurses with the required specialist competencies for the NRC although they would usually use the staff bank where possible to cover staff sickness.

Managers told us that arrangements for obtaining specialist agency staff, where needed for the NRC, were not in place ahead of the move to the trust, which had resulted in some initial challenges in covering shifts. It was sometimes difficult to secure bank or agency staff with the required competencies and they sometimes used staff from ward 22 at Scunthorpe hospital or
from a nearby private hospital, to cover shifts. Managers told us they used the trust ‘safe to care’ induction checklist with agency staff.

**Medical staffing**

The trust has reported their medical staffing numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>55.1</td>
<td>54.8</td>
<td>55.1</td>
<td>55.8</td>
</tr>
<tr>
<td>Goole District Hospital</td>
<td>4.6</td>
<td>5.5</td>
<td>4.4</td>
<td>5.2</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>51.3</td>
<td>52.4</td>
<td>51.1</td>
<td>53.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111.0</strong></td>
<td><strong>112.7</strong></td>
<td><strong>110.6</strong></td>
<td><strong>114.2</strong></td>
</tr>
</tbody>
</table>

In January 2018 the trust had a medical staff fill rate of 101.5%, with an over-establishment of 1.7 more WTE staff in post than the trust planned to provide safe and effective care. Goole District Hospital and Scunthorpe General Hospital both had an over-establishment of medical staff, whilst Diana, Princess of Wales Hospital had a fill rate of 99.6%, with slightly less WTE staff in post than planned.

*(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)*

**Vacancy, Turnover and Sickness Rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 28% in medicine;

- Diana, Princess of Wales Hospital: 24%
- Scunthorpe General Hospital: 30%
- Goole District Hospital: 58%

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

Staff and managers told us there was currently one vacancy for a junior doctor at GDH, which had been vacant for a few months.

From February 2017 to January 2018, the trust reported a turnover rate of 8% in medicine;

- Diana, Princess of Wales Hospital: 9%
- Scunthorpe General Hospital: 7%
- Goole District Hospital: 0%

*(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

From January 2017 to December 2017, the trust reported a sickness rate of 3% in medicine;

- Diana, Princess of Wales Hospital: 2%
- Scunthorpe General Hospital: 3%
- Goole District Hospital: 0%

*(Source: Routine Provider Information Request (RPIR) P19 Sickness)*
Bank and locum staff usage

From February 2017 to January 2018, the trust reported the following shifts for bank and locum staff:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>159</td>
<td>3,759</td>
<td>40</td>
</tr>
<tr>
<td>Doctor in Training</td>
<td>1,410</td>
<td>8,214</td>
<td>554</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>826</td>
<td>905</td>
<td>67</td>
</tr>
</tbody>
</table>

Goole and District Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor in Training</td>
<td>91</td>
<td>470</td>
<td>4</td>
</tr>
<tr>
<td>Middle Grade</td>
<td>20</td>
<td>24</td>
<td>3</td>
</tr>
</tbody>
</table>

The trust did not provide the total medical and dental shifts available including substantive staff; therefore, bank and locum usage cannot be calculated.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

In October 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 107 whole time equivalent staff working in medicine at Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (SpR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/10/2017 - 31/10/2017)

Medical cover at GDH was provided by three consultants and five middle-grade doctors. Managers told us medical cover was available 24 hours per day, seven days per week, for both wards.
Staff told us a general medical consultant was available two days per week, on ward 3. On the NRC, there were two specialist consultants, who were available one day each, per week, plus three floating sessions.

Staff and managers told us a junior doctor was available on site at GDH at all times and that they had completed advanced life support training. Managers told us all staff would be ILS trained in future. An anaesthetist was available on site during the day but not out of hours. The trust told us a middle grade orthopaedic doctor was also present on site between 8am and 8pm Monday to Friday who could provide additional support as required.

Out of hours, a resident middle grade doctor/RMO (general rehab) based on ward 3, covered the NRC and was responsible for inpatients on the Goole site. Staff told us consultant medical cover out of hours was provided by the RMO at Scunthorpe General Hospital. Staff would call or patients would be transferred to A&E at Scunthorpe if required. If tertiary care was required such as neuro, plastics, vascular medicine, staff would contact the NHS trust in Hull.

Information from the trust indicated the NRC was compliant with British Society of Rehabilitation Standards (BSRM) for a Level 2b unit for which the NRC was registered and NRC patients were assessed to be low risk and stable. A recent report to the strategic development board indicated staffing for the NRC was calculated in line with the acute stroke units and this was bringing the unit closer to the British Society of Rehabilitation Medicine standards for a level 2a/b unit. It was acknowledged this would require continued review depending on the acuity of the patient group and the planned expansion. Managers felt staffing levels ‘remained comparable’ to this standard although a consultant led service must be maintained with adequate doctor cover to provide day to day support for complex patients.

**Records**

The Trust was going through a transition from paper records to the Acute Electronic Patient Record in WebV which meant that both were required to be used.

During inspection we reviewed a sample of patient records. We reviewed medical and nursing notes for 18 patients at GDH. We completed five comprehensive reviews and we checked key assessments for a further 13 patients.

We saw that patient records were usually stored securely in a locked trolley or office, although we did see some patient information left unattended on the nurses’ station and computers left unlocked on occasion, during inspection.

We saw that a paper-based system was used which contained patient risk assessment and care plans, supported by the electronic patient board (WebV), where NEWS scores were recorded and displayed. We noted that entries in patient notes were usually signed and dated, but staff did not routinely print their name against all entries.

Information from the trust indicated that the NRC was in the process of reviewing its documentation to ensure its paperwork and risk assessments were fit for purpose and tailored to the needs of the individual, rather than a ‘one size fits all’ approach. NRC managers explained that an NLaG audit plan was now in place, which would include documentation audits going forwards.

A trust-wide audit of adult nursing documentation across all three hospitals in April 2018 had given the trust moderate assurance. This was an improvement on the previous audit which only gave limited assurance. Some of the areas that needed further improvement were identifiers on every page such as patient name, date of birth, NHS number and consultant. Discharge plans
and checklists were also an area for improvement, as was the use of a pain chart and the
documentation of evaluation of analgesia effectiveness.

A trust-wide documentation audit of medical records in May 2018 gave limited assurance, similar
to previous years. Like the nursing audit it showed that recording of demographic / patient
identifiers needed to be improved. Documentation of initial assessment using the CDU/AMU
clerking document was generally good, however it was also evident that documentation of
discussions with patients and or carers about their care needed to be improved and gaps in care
were also highlighted by the audit.

**Medicines**

During inspection, we looked at the arrangements for storage and administration of medicines,
and we reviewed a sample of prescription charts on each ward. We had some concerns about
medicines and pharmacy support.

A pharmacist visited ward 3 only once per week and there was no arrangement in place for
pharmacist support at the NRC. Managers told us this was because they were not included in the
current trust pharmacy service level agreement as they had only joined NLaG in September
2017. Staff told us the lack of pharmacy provision meant there was infrequent medicines
reconciliation, and stock checks were carried out by nurses on the ward, who told us they spent a
significant time arranging top up medicines. Staff reported that there were times when medicines
were needed and there was no top up available on site. When this happened, they would omit a
dose of medicine until the next day. Alternatively, if urgent, medicines could be sent via taxi from
Scunthorpe hospital (SGH) or the patient would need to be transferred to SGH, for example, to
receive IV medicines. We were not assured that staff always reported omitted doses or
unavailability of medicines as incidents.

Managers told us pharmacy provision was being reviewed at the time of inspection.

We saw that most medicines, including infusions on ward 3, were stored appropriately. However,
we also found liquid medicines on both wards without a date of opening noted. On the NRC,
there were also several examples of non-stock or borrowed items. However, there was also a
positive example of staff arranging to keep some specific antibiotics on site for one patient who
had twice previously had to transfer to SGH to receive these medicines.

On ward 3, there was evidence that staff checked fridge temperatures daily, to ensure medicines
requiring refrigeration were safely stored. However, records showed daily checks were not
routine on the NRC, with four examples in one month (April 2018), where temperatures had gone
out of range and there was no documented action taken.

We saw the pharmacy team carried out controlled drugs (CD) checks three times per year on
both wards. However, we also found that staff carried out CD stock checks weekly in line with
policy. Ward 3 had a register of patients' own controlled drugs in place, however the NRC did not.
On the NRC, we also noted that there were two sets of CDs which had been awaiting return to
pharmacy for some time.

Records on both wards showed good recording of antibiotic start / stop dates, allergy status and
Venous thromboembolism (VTE) assessment to ensure patient medicines were administered
safely. However, VTE assessments were not well-completed on the NRC and we saw one
medicines administration chart where the patient's weight was not recorded.

Staff we spoke with on the NRC were aware of the trust policy for safe administration of
medicines and the requirement to complete medicines administration training every three years.
Part of the adult nursing audit dashboard asked whether there was; more than two omitted doses of one or more medicines, was the reason for omission documented and was appropriate action taken regarding the omitted dose. There was no evidence that this had been audited on the medical wards at GDH.

**Incidents**

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From February 2017 to January 2018, the trust reported no incidents classified as never events for medicine.

*Source: NHS Improvement - STEIS (01/02/2017 - 31/01/2018)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from March 2017 to February 2018.

A breakdown of the incident types is shown below:

- Six medication incidents meeting SI criteria (30% of total incidents).
- Four treatment delays meeting SI criteria (20% of total incidents)
- Four pressure ulcers meeting SI criteria (20% of total incidents)
- Two surgical/invasive procedure incidents meeting SI criteria (10% of total incidents)
- Two slips/trips/falls meeting SI criteria (10% of total incidents)
- One pending review (5% of total incidents)
- One commissioning incident meeting SI criteria (5% of total incidents)

12 of the 20 incidents occurred at Scunthorpe General Hospital and eight at Diana, Princess of Wales Hospital. No serious incidents were reported at GDH during the period.

*(Source: Strategic Executive Information System (STEIS))*

Data provided by the trust showed the number of incidents reported by staff on the medical wards at GDH was 136 from January 2017 to April 2018, 128 of these were reported as taking place on ward 3 and eight on the neuro-rehabilitation unit. However, there was no breakdown relating to the degree of harm. We were concerned there was under-reporting of medicine incidents.

We discussed incidents and reporting with managers and staff on both wards.

Managers on ward 3 reported one serious incident, relating to a patient fall, in the past 12 months.

Managers on the NRC reported that since becoming part of the trust in September 2017, there had been two other incidents, which were being investigated at the time of our inspection (one serious incident since February 2018) and two RCAs relating to patient falls on the unit. We reviewed the initial serious incident report relating to missed medicines and the use of a nasogastric tube.
Staff on both wards told us they could access the trust incident reporting system and knew how to report incidents. Ward 3 staff received feedback on incidents on the ward and from other areas in the trust via email and in the daily ward safety briefs. Therapies staff were made aware of incidents at therapy team meetings and there was a ‘lessons learned’ folder available. However, some staff were unable to give us examples of learning from incidents from other areas in the trust.

We saw posters about the duty of candour on both wards and staff were aware of the need to be open, although they were less familiar with the trust policy.

Managers told us there was work ongoing to improve the mortality review process and more closely align this with the trust’s SI process. As part of the mortality review programme, where a reviewer felt care had been poor or concerning, they would refer for a second review.

We reviewed minutes from the respiratory and gastroenterology department’s mortality and morbidity meetings, which showed discussion and learning points from the review of mortality cases and pathway audit. There was evidence of action to improve the services and identification of factors which may affect mortality outcomes such as: For gastroenterology; length of stay in the emergency department, getting the patients into the right bed and lack of alcohol liaison services. There was also the recognition of things that had made a difference in other services such as having a specialist, respiratory in reach nurse to ensure patients were on the correct pathways and had appropriate care plans. The respiratory minutes highlighted similar issues such as length of stay in ED and the number of deaths outside of the respiratory ward.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 124 new pressure ulcers, 26 falls with harm and 15 new catheter urinary tract infections from December 2016 to December 2017 for medical services.

From June 2017 to May 2018 we saw that the percentage harm free care for ward 3 GDH ranged between 71% and 100%. There were no dips in performance over the year of below 70%. There was no data for the neuro-rehabilitation unit.

We saw safety thermometer data from January to March 2018 displayed on ward 3 at GDH. This indicated that during this period, there were two patients with pressure ulcers, two patients with a catheter, no patients with a urinary tract infection, no patients with blood clots and no patient falls. The NRC did not yet collect or display safety thermometer data.

Safety thermometer data was not displayed at the NRC at GDH. Managers told us that although the service did not currently participate, data collection was scheduled to start and managers were now aware of trust requirements for this. Managers told us that slips, trips and falls were the most common type of incident on the unit. The ward manager told us no NRC patient had ever had a pressure ulcer develop on the unit.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Northern Lincolnshire and Goole NHS Foundation Trust**
Total Pressure Ulcers (124)

Total Falls (26)

Total CUTIs (15)

Source: Safety thermometer - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

Staff had access to trust policies via the trust intranet hub. Patient records from both wards showed staff used a number of standardised care pathways to plan care for patients. We looked at some of the trust’s clinical protocols and patient pathways used for patients on medical wards; this included the trust’s stroke, non-invasive ventilation and skin integrity pathways. We found that these followed nationally recognised best practice and current evidence base. The pathways were clear and easy to follow.

Managers at the Neuro Rehabilitation Centre (NRC) told us it worked towards many of the trust policies and procedures before becoming part of the trust and that staff knew where to find them and had access to NLaG systems before the transition.

The trust took part in several national and local audits. Both the NRC and ward 3 had completed infection prevention and control and environmental audits. The ward assurance tool the ‘Adult Nursing Audit Dashboard’ and matron observational audit were used to monitor standards of patient care on ward 3, but we did not see this in use on the NRC.

There was evidence of specific nursing audits at the trust’s other two hospitals, such as recording of food and fluid intake, omitted medicines and completion of risk assessments; however, we were not provided with evidence of these audits for wards at Goole.

Managers told us that an audit plan had recently been put in place for NRC, to bring it in line with trust expectations, a number of audits were scheduled to begin in May 2018 and some additional staff resource had been identified to support this. This meant the NRC could not yet demonstrate
compliance with trust policies in areas such as record-keeping and patient safety.

The NRC submitted data to the specialist Rehabilitation Outcomes Collaborative (UKROC), a national benchmarking database on a fortnightly basis. Nursing and therapy staff were involved in ROC data collection.

Managers told us the service worked to the national guidelines set by the British Society of Rehabilitation Medicine, and the lead consultant was part of a working group looking at the specialist needs patients in prolonged disorders of consciousness. It was unclear whether the NICE guidelines on stroke were in use on the ward.

**Nutrition and hydration**

During inspection, we saw staff used the ‘my life’ booklet to record patients’ individual preferences and needs for nutrition and hydration, for example, a person’s likes and dislikes for food and whether they prefer to use a cup, beaker or mug. Staff also highlighted patients with nutrition and hydration needs using symbols on the electronic patient board system (WebV) and using stickers in patient records (ward 3). Records showed staff completed risk assessments to identify and monitor patients’ risks and completed several care rounds during the day.

On ward 3, we did not see fluid balance charts recorded in patients’ notes (such as where a patient had minimal fluid intake the previous day) and on the NRC, we saw that some patients’ nutrition and hydration risk assessments were not reviewed weekly, as per trust policy. NRC records showed that for three patients receiving enteral nutrition (naso-gastric (NG) or percutaneous endoscopic gastrostomy (PEG) feeding) and one patient receiving nasogastric feeding, there were no food and fluid charts in patient notes. This meant there was a risk that patients’ intake was not routinely monitored and staff may not have the information they need to evaluate whether patients had taken enough food or fluid or to make fully informed decisions about next steps of care. We raised this with managers, who confirmed that food and fluid charts should be in place.

For the records we reviewed, there was no post-PEG care plan in place, which meant staff did not have an easily identifiable record of care for patients using feeding tubes. Following inspection, we were provided with an example care plan, policy and guidance and were told this was available to staff via the trust intranet. However, we did not see this in use during inspection for a patient receiving enteral nutrition via PEG. A recent serious incident had highlighted a need for training for staff in caring for patients with a nasogastric feeding tube. Staff told us there had been one complaint relating to PEG insertion for nourishment on NRC.

We saw staff encouraged patients to eat in the dining room on the NRC and we observed staff supporting patients appropriately, to eat and drink. Staff told us patients were supported to take part in cook and share activities e.g. to cook breakfast once a week to share with staff. Staff told us this was a valuable time to interact with patients, however cooking activities had been suspended since October 2017 as the therapy kitchen was not currently available for patient use. We did not see facilities for patients to make a drink available in the day room.

Staff told us specific diets could be facilitated and patients were supported to order take-away food sometimes, if able. Information about patient dietary requirements was available for staff on the WebV electronic system and on the board in the kitchen.

Most patients on ward 3 told us the hospital food was good quality, with enough choice. However, some patients on both wards told us the menu was repetitive or had a limited choice and that this could be frustrating for patients who stayed a long time in hospital for rehabilitation therapy.

Part of the adult nursing audit dashboard covered a number of food and hydration indicators from
risk assessments to completion of food and fluid records. However, there was no evidence that this had been audited on the medical wards at GDH.

Pain relief

We saw that staff checked on the patient’s level of pain routinely as part of comfort rounds and that evaluation of pain was documented in patients’ nursing records.

Trust staff used the Abbey pain scale for patients with dementia and could access specialist nurses for support if needed to help assess pain for patients with learning disability or dementia.

Patient outcomes

We reviewed a sample of patient records during inspection. We saw that staff on the NRC used nationally recognised patient outcomes measures, such as the functional independence measure and the functional assessment measure (FIM/FAM), which is linked to the UK ROC national dataset, as well as the Barthel scale and Rivermead mobility index.

Relative risk of readmission

Trust level

From November 2016 to October 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in medical oncology had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a lower than expected risk of readmission for non-elective admissions

Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.
Non-Elective Admissions – Trust Level

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: HES - Readmissions (01/11/2016 - 31/10/2017))

Goole & District Hospital

From November 2016 to October 2017, patients at Goole & District Hospital (Acute) had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions
- Patients in pain management had a higher than expected risk of readmission for elective admissions
- Patients in general medicine had a higher than expected risk of readmission for elective admissions
- Patients in general medicine had a higher than expected risk of readmission for non-elective admissions

Elective Admissions - Goole & District Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions - Goole & District Hospital
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

**Sentinel Stroke National Audit Programme (SSNAP)**

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest the audit, April to June 2017.

*Source: Royal College of Physicians London, SSNAP audit*

There was no data specifically for GDH as the numbers of stroke patients were too few to report.

**Lung Cancer Audit 2017**

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 84.7%, which did not meet the audit minimum standard of 90%. The 2016 figure was 67.4%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 13.7%. This was within the expected range when compared to the national average of 17.5%. The 2016 figure was not significantly different from the national level.

The proportion of fit patients with advanced NSCLC receiving Systemic Anti-Cancer Treatment was 51.4%; this was within the expected range when compared to the national average of 62.0%. The national aspirational standard was 60%. The 2016 figure was not significantly different from the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 67.2%; this was within the expected range when compared to the national average of 68.0%. The national aspirational standard was 70%. The 2016 figure was not significantly different from the national level.

The one-year relative survival rate for the trust was 32.6% which was within the expected range when compared to the national rate of 37.0%. The 2016 figure was not significantly different from the national level.

*(Source: National Lung Cancer Audit)*

**Mortality Outliers**

The trust currently has two active mortality outliers. One is under consideration by the outliers’ panel (heart valve disorders from September 2017) and one case where action plans are being followed up by local inspection team (septicaemia (except in labour) from September 2016).

*(Source: CQC Outliers Programme)*

**Competent staff**

**Appraisal rates**

From April 2017 to January 2018 63.4% of staff within medicine at the trust had received an appraisal compared to a trust target of 95%. Compliance at GDH was around 78%.

A split by site and staff group can be seen in the graph below:
Goole District Hospital

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>14</td>
<td>15</td>
<td>93.3%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>17</td>
<td>20</td>
<td>85.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medical staff</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>0</td>
<td>4</td>
<td>0.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff told us and staff rotas confirmed that new nursing staff worked in a supernumerary capacity for two weeks. New starters completed local induction to fire and emergency procedures, escalation and crash call training at GDH. One new starter was scheduled to attend the trust induction within two months of starting and had a log-in to access the trust intranet. Managers told us they used the trust ‘safe to care’ induction checklist with agency staff.

Staff, including student staff members told us they received an annual appraisal and were able to identify learning and development needs and access support and training as needed.

At the time of inspection, 83% of nursing staff on ward 3 had received an annual appraisal. Managers told us this may not be fully accurate as there was a delay in completed appraisals showing on the system and some retire and return staff records had been lost.

On the NRC, 60% of all staff had received an appraisal, against the trust target of 95%. Managers explained the NRC rate did not relate to a full year as the service became part of the trust in September 2017.

Staff told us all nurses on the NRC (except one new starter) had completed mandatory internal training in caring for patients with a tracheostomy, as well as additional external training. However, nurses were not trained to change tracheostomy tubes (one nurse was partway through this training). For tubes that needed changing during the day, staff would contact medical staff and there was a surgeon and anaesthetist on site who would respond. Alternatively, a specialist nurse at SGH would do the changes. Out of hours, staff would call 999 for assistance and transfer to SGH.

Staff also told us that the training and development lead had done some competency-based training for staff when a patient with a nasogastric feeding tube was admitted. However, they were not trained to replace tubes which was a medical task. There had been one incident where a tube had been out for an extended period, due to a doctor being called to another emergency, which had resulted in a critical medicine being missed. This had been reported as a SI and was under investigation.

Managers told us all nurses on the NRC completed level 1 food hygiene training and the therapy team completed level 2, to enable them to safely use the therapy kitchen to support patients.

Staff told us it was sometimes difficult to access training because it was usually held at Scunthorpe or Grimsby hospital sites.

Ward 3 supported a student nurse placement. The NRC supported NVQ level 3 study for
therapies assistants.

**Multidisciplinary working**

Staff we spoke with told us that they had positive and supportive relationships with the multidisciplinary team (MDT) for example, medical staff, specialist nurses, therapists, dieticians, social care workers, mental health liaison and community teams.

Staff told us there were daily MDT handovers and printed information with patient details was available for staff from the electronic patient board (WebV) system.

On the NRC, a multidisciplinary team (MDT) meeting was held weekly to discuss patients’ needs and review progress towards goals and outcomes. We observed an MDT meeting at the NRC and we observed nurses, medical staff and therapists working together to set and agree patient goals, review progress, plan discharge and discuss ongoing care with families. MDT ward rounds took place twice weekly on the NRC.

NRC staff told us MDT working relationships could be further improved between nursing and therapy teams, handovers were completed separately and lines of responsibility had previously been unclear.

**Seven-day services**

Managers told us medical cover was available 24 hours per day, seven days per week, for the whole GDH site.

Consultant ward rounds took place twice weekly on ward 3 and weekly on the NRC. Patients on ward 3 told us they saw a doctor every day. Staff told us patient admissions were limited to three days, to ensure patients could be seen by a consultant within 24 hours.

On ward 3, physiotherapy was provided seven days per week.

On the NRC, physiotherapy and occupational therapy support were available five days per week. Out of hours on-call physiotherapy support was provided by Scunthorpe hospital, although physiotherapy staff provided support on an informal basis and managers told us they were in the process of formalising this into a GDH on-call rota. Speech and language therapy (SALT) was available three days per week and psychology input was available four days per week. A dietician came to the ward once a week and staff could make a referral if they had any concerns. No therapy input was available at the weekend.

**Health promotion**

During inspection, we saw a variety of posters and information displayed about healthy living and support, for example, leaflets about health trainers, home safety, living aids, and antibiotics advice.

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

Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack
the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLS). DoLS can only be used if the person will be deprived of their liberty in a care home or hospital.

We looked at the trust's policies for consent and mental capacity act, including DoLS. We found that these were in date and contained appropriate references to legislation such as the mental capacity act, equality and diversity and the human rights act.

NRC staff told us patients were assessed for capacity on a decision by decision basis and patients were initially asked to give their consent to come to a locked ward. We reviewed a sample of patient records including mental capacity assessments and ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) forms on the NRC. This indicated the psychologist carried out a two-stage mental capacity assessment and these were completed in full, including reasons why a person did not have capacity for a decision.

We saw appropriate DoLS applications had been made to the local authority where required. We saw an example of a best interest decision form, which was completed appropriately and included options, outcomes, next steps and there was evidence of patients’ families being involved. We saw MDT discussion in these cases and it was documented that the patient was informed using verbal and pictorial information to explain.

Managers told us a bespoke safeguarding training session had been recently held, which included information on the Mental Capacity Act and DoLS and that they worked closely with the trust safeguarding leads on these issues.

Staff told us that they held safety briefs every morning and any patients on DoLS were mentioned so all staff were aware. All staff interviewed knew how to contact the mental health via the switchboard, either with a crisis, or ongoing mental health services.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that Mental Capacity Act (MCA) training had been completed by 75% of staff and Deprivation of Liberty training had also been completed by 77% of staff within medicine at May 2018.

The trust safeguarding lead told us that trust wide as of end of April: Mental Capacity Act (MCA) training was at 74%; DoLS training Level 1 was 77% and Level 2 was 56%. The trust was currently reviewing which staff need level 2 training for DoLS. MCA and DoLS training was delivered together with a focus on consent to treatment. Best Interest assessors within the trust had separate additional training.

The trust safeguarding lead identified Level 3 training as a priority for the trust, together with making sure DoLS training is embedded.

**Is the service caring?**

**Compassionate care**
**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 44% which was better than the England average of 25% from December 2016 to November 2017.

**Friends and family test – Response rate between 01/12/2016 to 30/11/2017 by site.**

![Graph showing response rates for different hospitals](image)

Goole District Hospital only achieved six responses in total for this core service so there is no table of data available.

*(Source: NHS England Friends and Family Test)*

During our inspection we spoke with 14 patients and family members on both wards.

Patient and families’ comments were very positive about ward 3, especially the calm atmosphere, speed of response and caring approach of staff. We saw that patients had call bells, drinks and bedside tables within reach and staff responded in a timely way. Patients told us there were enough staff to meet their needs and call bells were answered promptly, including at night.

We saw that curtains were drawn around bed spaces on ward 3 and patients were cared for in individual rooms where possible on the Neuro Rehabilitation Centre (NRC), to maintain patients’ privacy and dignity. Patients on ward 3 told us staff introduced themselves and explained what they were going to do, when carrying out cares, checks and treatment. We saw an information board in the rehabilitation gym with therapist names and roles. Patients and families on the NRC told us that new staff came to introduce themselves and got to know patients well who have been on the unit for a long time.

We reviewed data from the NRC patient satisfaction questionnaire March 2017 to March 2018. This showed 92% of families and commissioners were likely or extremely likely, to recommend the service. Patient and families’ responses were very positive about the NRC. One relative had written; ‘if one is unfortunate enough to have a brain injury I cannot think of a better place to be’. And another said; ‘My wife’s stay in GDH made a huge contribution to her recovery’. Data showed 100% patients agreed they were treated with respect by staff and 91% agreed they could speak with a member of the management team if they needed to.

We saw friends and family feedback cards available for patients on both wards.

**Emotional support**

Staff on the NRC used the ‘my life’ booklet to record patients’ individual preferences and needs.
This included information on what is important to the person and topics the person does / does not want to discuss as well as how best to support them, their hobbies, likes and dislikes and usual sleeping pattern.

We observed staff offering patients emotional reassurance when delivering cares and caring, private support if a patient was upset and psychology support was provided for families on the NRC. Staff told us some patients made a positive choice to stay at GDH for end of life care.

Families on ward 3 told us staff explained what was happening to their relatives and encouraged them to look after themselves as carers too. Families on the NRC told us staff were supportive and understanding if they were not having a good day and staff gave examples of where they had advocated for patients to funders and other healthcare professionals to support families.

Staff on ward 3 told us they had introduced extended visiting hours as ‘theme of the month’ to increase patient time with families. Staff on the NRC told us patients could personalise their rooms with pictures and personal items, to make them feel more at home during a long stay.

**Understanding and involvement of patients and those close to them**

We observed a multidisciplinary team meeting at the NRC and we observed nurses, medical staff and therapists working together to set and agree patient goals, review progress, plan discharge and discuss ongoing care with families.

We saw evidence of appropriate patient involvement in the records we reviewed. For example, we saw evidence of patient-centred goal setting, patients and families contributing to decision-making and conversations with patients and families being appropriately documented.

We reviewed NRC patient questionnaire data from March 2017 to March 2018. This showed that 100% patients agreed staff explained reasons for treatment and actions and used the body goals sheet. However, the service had also identified some areas to work on, as 25% of patients said they were not sure who their key worker was; 20% did not agree that staff responded quickly if patients’ needed help; 19% said staff did not communicate with them in way they could understand; and 9% of families said they were not kept informed enough about their relative’s progress.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Ward 3 was a 15-bedded ward for patients with general rehabilitation or complex discharge needs, including four dedicated beds for stroke patients.

The Neuro Rehabilitation Centre (NRC) was a regional specialist centre with 12 beds for inpatient assessment and rehabilitation for people with acquired brain injury and complex neurological conditions. It could provide a service for people across the region as well as the immediate local population and worked with a variety of CCGs to facilitate this. Patients may stay on the unit for up to 12 months and their progress and further rehabilitation potential was assessed every 12 weeks.

Both ward 3 and the NRC at GDH received only planned admissions and completed an assessment to identify people’s individual needs and suitability before admission. MDT staff including for the NRC, a consultant, psychologist and physiotherapist were involved in this assessment. Both used the electronic patient board (WebV) system and the trust ‘my life’ booklet and to highlight people’s individual needs and support staff in delivering care to meet those
Staff used a patient questionnaire and a patient forum to identify areas for improvement.

Managers told us the trust strategic board had identified an increasing need for the NRC service and in response, plans to relocate ward 3 to allow for expansion were developed and discussions with CCGs and links to the local STP were ongoing.

**Average length of stay**

**Trust Level**

From December 2016 to November 2017 the average length of stay for medical elective patients at the trust was 4.8 days, which is lower than the England average of 5.8 days. For medical non-elective patients, the average length of stay was 7.1 days, which is higher than the England average of 6.5 days.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in gastroenterology is higher than the England average.
- Average length of stay for elective patients in medical oncology is higher than the England average.

**Elective Average Length of Stay – Trust Level**

![Chart showing average length of stay for elective specialties at the trust and England average.]

*Note: Top three specialties for specific trust based on count of activity.*

**Average length of stay for non-elective specialties:**

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in geriatric medicine is lower than the England average.
- Average length of stay for non-elective patients in respiratory medicine is higher than the England average.

**Non-Elective Average Length of Stay – Trust Level**

![Chart showing average length of stay for non-elective specialties at the trust and England average.]

*Note: Top three specialties for specific trust based on count of activity.*
Note: Top three specialties for specific trust based on count of activity.

Goole & District Hospital

From December 2016 to November 2017 the average length of stay for medical elective patients at Goole & District Hospital (Acute) was 1.0 days, which is lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 12.9 days, which is higher than England average of 6.5 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical haematology is lower than the England average.
- Average length of stay for elective patients in gastroenterology is lower than the England average.

Elective Average Length of Stay - Goole & District Hospital (Acute)

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is higher than the England average.
- Average length of stay for non-elective patients in clinical haematology is lower than the England average.

Non-Elective Average Length of Stay - Goole & District Hospital (Acute)
Meeting people’s individual needs

The trust had a full time Quality Matron with the strategic lead for dementia and learning disabilities across the trust and there was a full time Dementia Specialist Nurse and a part-time Learning Disability (LD) Specialist Nurse based at SGH and DPoW who were available to support staff at GDH.

The specialist nurses were available to review patients in terms of nutritional and fluid intake, pressure areas, pain assessment (use of Abbey pain scale), falls risk and to support the nursing staff. They also reviewed medication and the use of sedatives and anti-psychotics. They were available to support staff with capacity assessments, best interest decisions and DoLS if needed.

The specialist nurses were notified of all admissions through the IT system and could be contacted by phone/bleep if a ward needed immediate advice or wanted to request support. There was a prompt on the nursing admission for documentation for staff to contact the LD specialist nurse when an LD patient was admitted.

The quality matron for dementia and learning disability told us that dementia training was mandatory for all staff who come in to contact with patients. The training target for this training was 85% at tier 1 and tier 2 the achievement was 86% and 71% respectively at trust level. They told us that every ward has a dementia champion who attends a quarterly meeting led by dementia specialist nurse.

The dementia lead told us that as the trust does not have dementia specific wards, this made environmental changes difficult. However, now all wards have plain curtains and dementia friendly signage. They told us that there was Board commitment to improve the wards to dementia friendly environments when refurbishment takes place.

The hospital had the facilities in place to access interpreter services over the telephone. Staff were also able to request face-to-face interpreters. The service providers could translate documents into different languages when necessary. British Sign Language Interpretation was also available for patients who are deaf or hard of hearing.

During inspection, we saw staff managing challenging behaviour and making reasonable adjustments to ensure people with a disability received a service on an equal basis with others. For example, we saw staff taking time to ensure a patient with a hearing impairment on ward 3 had understood and was happy with what was happening before and during cares. Staff told us that a member of the team would accompany patients to appointments off-site, to support them as needed.

Both ward 3 and the NRC used the electronic patient board (WebV) system and the trust ‘my life’ booklet and to highlight people’s individual needs and support staff in delivering care to meet those needs, including the communication needs of people with a disability or sensory loss.
Staff completed dementia awareness training and told us they could access support from specialist dementia nurses based at Scunthorpe hospital.

On ward 3 we saw staff used a file of photographs of meals to help patients with communication difficulties or those who could not speak English, to select menu choices. We saw one NHS information leaflet available in Polish, although this was not specific to the hospital. Staff gave an example of having arranged to work with an interpreter recently, to support a patient.

Ward 3 had pictorial signage on toilets and bathrooms, designed to support people living with dementia, although we did not see other dementia adaptations in use e.g. red plates and cups which help patients at mealtimes. There was also a pay phone on ward 3 for patients to use, which was at a suitable height for a wheelchair user to access.

The NRC used some pictorial signs e.g. flowers for the garden and some bespoke signs with a patient’s name, to enable them to navigate to and from their room.

Staff told us they had identified some delays in accessing wheelchair assessments for patients and so had developed contacts in local areas to address this.

There was a multi-faith prayer space available and a chapel, on the GDH site.

We observed an MDT meeting where nursing, medical and therapies staff worked together to plan complex discharges and discussed people’s ongoing needs with relatives. We saw that discharge summaries for patients leaving the NRC were prepared by medical staff and sent to the patient’s GP and other appropriate teams, to facilitate continuity of care. These included in depth clinical summaries, a plan and requested actions, and information about medicines.

NRC therapies staff conducted home visits and vocational visits with patients e.g. to a person’s workplace, to support their rehabilitation. Staff designed person-centred therapy plans and flexed timetables to match people’s energy levels and balance input from other MDT professionals. Staff supported people to take part in a variety of activities including swimming, using adapted bikes or a local walking group, woodwork activities, gardening and social interaction, appropriate to their ability and goals.

Staff gave examples of engaging person-centred goals, for example one patient was able to go to the pub with family and order his drinks and staff described the positive impact on mood and engagement in therapy activities. A recent report to the trust board highlighted another example; ‘NRC has visits from Purdy, a German Shepherd, who is trained as a Pets as Therapy dog. She comes most Fridays and it is the highlight of the week for patients. She has given one patient the courage to work on his outdoor mobility, and encourages patients to reach and stretch which is an adjunct to hand and upper limb therapy’.

Ward-based therapies staff flexed timetables and sessions to meet people’s individual needs and energy levels. Staff supported patients to access outpatient appointments at other hospitals as needed. However, staff told us that referral processes, ambulance transport bookings and communication with other parts of NLaG were not always smooth and sometimes resulted in delays for patients.

During inspection, we saw a variety of leaflets for local organisations and support services displayed on each ward, including information about support for carers and local organisations supporting people living with dementia. We saw that the NRC had engaged with the trust communications team to develop a new patient information brochure about the service and what to expect.
Access and flow

Over the past 12 months to April 2017, ward 3 had 39 patient admissions. The ward received no direct admissions. Patients were transferred from other areas of the trust or from hospitals in other localities. Staff told us patients usually came to the ward for rehabilitation, although some were instead awaiting complex discharge arrangements to be put in place. Occasionally, ward 3 received surgical outliers from the GDH surgery department.

Staff told us that patient discharges from ward 3 could be delayed because of waiting for packages of care to be put in place or because of delays with requesting ambulances. Staff were required to give 24 hours’ notice for an ambulance transfer as no same day transfers were available and this had caused problems. Staff also told us sometimes patients could not receive a scan on the same day.

Over the past six months, (from Sept 2017 to Feb 2018) the NRC had seen a total of 54 referrals from 11 different hospitals and 3 home referrals from GPs. Due to the nature of the service, all NRC admissions were pre-planned and patients stayed between six and 12 months on the unit. We reviewed a report to the NLaG board which showed NRC bed occupancy had remained above the 93% target occupancy for six of the past seven months from September 2017 to April 2018, with an average occupancy of 96%.

Patient records showed patients were seen by a consultant at least weekly while on the NRC and a weekly MDT meeting was held to discuss patients’ needs in depth.

Medical staff might decide to transfer a deteriorating patient via emergency ambulance to Scunthorpe hospital. Staff told us there had been six patients transferred out since the unit had become part of the trust.

NRC managers told us they had admitted two outlying patients from other parts of the hospital, to help with winter pressures, since becoming part of the trust in September 2017. These patients had been assessed by medical staff and deemed suitable for admission.

Staff told us that a blood collection service operated twice daily, meaning that out of hours blood was sent via taxi to Scunthorpe, if necessary.

Referral to treatment (percentage within 18 weeks) - admitted performance

From January 2017 to December 2017 the trust’s performance has been stable but consistently worse than the England average.

In the most recent month, December 2017, the trust’s referral to treatment time (RTT) for admitted pathways for medicine showed 69% of this group of patients were treated within 18 weeks versus the England average of 89%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Two specialities were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>94.9%</td>
<td>93.2%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>62.5%</td>
<td>93.6%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Patient moves per admission

The trust provided data on patient moves per admission for non-clinical reasons for each hospital site. However, they did not supply a break down at individual ward level and as such it should be noted that the figures below could include figures for both surgical and medical wards.

Trust level:

During 2017, 95% of patients at trust level did not move wards during their admission, with 4% moving once and the remaining 1% reported moving wards more than once.

Goole District Hospital:

During 2017, 99% of patients at GDH did not move wards during their admission, with the remaining 1% of patients moving once or more. Only five patients were moved twice or three times. The number of bed moves was an improvement on the previous year. Trust data showed that from January 2017 to December 2017 there were 13 patients moved at night at GDH.

(Source: Trust Routine Provider Information Request - P51 – Bed moves)

Mixed Sex Accommodation Breaches

There were no mixed sex accommodation breaches reported for GDH from February 2017 to January 2018.

Delayed Discharges

We looked at the trusts delayed discharge figures from February 2017 to January 2018. There were 93 reported delays for ward 3 at GDH. The number of delays varied over the 12-month period ranging from 12 to three delays a month.

Learning from complaints and concerns

From February 2017 to February 2018, there were 115 complaints about medical care across the trust. The trust took an average of 52 working days to investigate and close complaints. This is
not in line with their complaints policy, which states complaints should be completed within 30-45 working days, or 60 days for complex complaints. There were four complaints about medical services at GDH.

A breakdown of the main subject of complaints is shown below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>63</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>13</td>
</tr>
<tr>
<td>Communications</td>
<td>12</td>
</tr>
<tr>
<td>Values &amp; behaviours (staff)</td>
<td>7</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>6</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>3</td>
</tr>
<tr>
<td>Appointments</td>
<td>3</td>
</tr>
<tr>
<td>(blank)</td>
<td>2</td>
</tr>
<tr>
<td>End of life care</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify in comments)</td>
<td>1</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

During inspection, we saw complaints leaflets and information about the patient advice and liaison service displayed on each ward.

NRC staff told us they had received one complaint since becoming part of NLaG in September 2017. Ward 3 staff told us there was one pending complaint at the time of inspection. Staff told us learning from complaints could be shared via staff meetings.

**Compliments**

From February 2017 to January 2018, the trust reported 30 compliments for medical care being logged by a central team on the DATIX system. 15 of these were for Diana Princess of Wales Hospital, 13 were for SGH and the final two were for GDH. Please note however, that any compliments sent directly to staff members are not logged using this system, therefore we are unable to know the exact number received by the trust.

The trust did not provide any additional information about these compliments; therefore, we are unable to comment on themes.

(Source: Routine Provider Information Request (RPIR) Compliments)

**Is the service well-led?**

**Leadership**

The medical service was led by a triumvirate of a divisional clinical director (DCD), associate chief operating officer and an associate chief nurse. The divisional clinical director and the
associate chief nurse (ACN) were both recently appointed to their roles.

The senior leaders were working to improve team working and share good practice / more effective ways of working across the hospital sites. They recognised that there were different ways of working at SGH and DPoW and each hospital had its strengths and weaknesses. They were aware of the difficulties they faced to encourage changes in practice to make services more streamlined and equitable in terms of quality and effectiveness.

The team told us they were aware the trust board had not always been fully supportive of implementation of difficult (agreed) change and told us they had been clear with the board that they needed their full support and backing when difficult choices / changes were made. The senior leaders felt that changes to the board of directors had been positive and that they had the board’s support.

We found that there was a clear leadership structure at clinical level. All wards had a ward manager who were supported by operational and quality matrons and the ACN.

Staff on both wards told us local leaders were approachable and supportive and ward managers worked clinical shifts as part of the ward team. Ward managers were planning to work more closely together to ensure their voice was heard by the trust and reported good support from senior nurses at the trust. Medical staff told us they felt supported by the medical director, although they could not always attend consultant meetings held at SGH or DPoW.

We discussed leadership with Neuro Rehabilitation Centre (NRC) staff who told us there had been some issues regarding the leadership structure and clarity of roles and responsibilities which resulted from a long period where the senior nurse role on the NRC had been vacant. Staff did not feel senior professional support for therapies teams such as physiotherapy was clear, in part because senior staff were based at Scunthorpe.

We discussed leadership arrangements with managers at the NRC since joining the trust, who described good support from directors and the trust chair. There was an allocated non-executive director for the unit and a strategic development board which met monthly. This was chaired by the deputy chief executive and was supported by the deputy directors of finance and estates. However, managers told us it was acknowledged that senior trust managers had not had a full understanding of the work of the NRC ahead of the service becoming part of the trust and this had impacted on the transition. For example, arrangements for pharmacy provision and specialist agency staffing were not in place before the unit became part of NLaG. Also, the new senior nurse on the NRC did not initially have a trust matron to report to, which meant there had been some delays in establishing the trust requirements e.g. for clinical audits, resuscitation equipment checks and safety thermometer reporting. The NRC was led by the trust’s community division. Some staff questioned this arrangement as the NRC service was a hospital-based specialist rehabilitation service for long-stay patients.

Vision and strategy

The Trust was in the process of refreshing its strategy which covered the period 2016-2019 and there was no overarching, fully developed strategy or business plan for the medical service for 2018/2019 but we saw for 2017/2018 there was a business plan that covered SGH, DPoW and GDH. This took into consideration commissioning intentions and the strategic transformation plan objectives. There was an analysis of the strengths, weaknesses, opportunities and threats to the service and several priorities for improvements and developments were tabled.

There was a trust wide staff retention strategy which focussed on delivering; culture transformation, instilling pride and belonging within the workforce, a review of reward and recognition incentives, staff wellbeing initiatives, staff engagement regarding quality
improvement, career investment and looking at improving the work/life balance of all staff. We found evidence that the triumvirate were aware of this strategy and were working towards delivering the outcomes. We saw evidence that the DCD and ACN were working with staff to improve engagement and improve services. The ACN was a good role model regarding caring for staff and thereby improving care for patients.

The dementia lead told us there was a dementia strategy and plan and the trust had recently introduced a delirium policy and care plan as part of this. A local dementia steering group had been formed and was co-chaired with a member of the commissioning group. The trust was also working with the Humber Coast and Vale STP steering group. The dementia lead had a clear vision and focus for the next 12 months and understood the challenges to delivery.

There was a local strategy for the NRC, which was part of the community services division. Staff we spoke with at GDH understood the local vision was to move ward 3 and expand the specialist Neuro Rehabilitation Centre (NRC) service to provide more beds to meet increasing demand for the service across the Yorkshire and Humber region. However, the timescale for change was uncertain as the planned expansion was dependent on the re-commissioning of ward 2, which had been delayed. NRC managers had recently presented a paper to the trust board to secure support in progressing the timetable for this work.

Some staff told us they did feel they had been well informed or supported, but others did not, when the NRC became part of NLaG and when the minor injuries unit (MIU) on site had transferred out of the trust to another provider. The transfer meant MIU staff no longer provided support to the NLaG wards out of hours and some staff told us this made them feel unsupported and isolated in an emergency.

We did not see information about the wider trust vision and values displayed on the wards at GDH and staff were not aware of the trust-wide vision.

Culture

Staff told us the culture of the NRC unit had become more patient focussed since becoming part of NLaG and there were now more therapy staff on the ward to support patients. Staff told us they had previously been encouraged to be innovative and hoped this would not change with the transfer to NLaG. Staff told us that MDT working was improving.

Staff told us that links to the trust could be improved, for example by providing more training on site at GDH to avoid staff having to travel to Scunthorpe or Grimsby, by making the referral process to other parts of NLaG smoother for patients and by creating opportunities for admin staff to support each other.

Several staff told us they enjoyed their work with patients at GDH and would not work anywhere else. Some staff told us the slow pace of change at the trust could be frustrating.

Governance

The medicine group had a clear governance structure for acute and planned care. Governance structures were in place that provided assurance of oversight and performance against safety measures. We reviewed the quality and safety committee minutes and found comprehensive discussion around current risks and performance. Information was discussed at these meetings from the different speciality groups.

There was evidence of specific nursing audits at the trust’s other two hospitals, such as recording of food and fluid intake, omitted medicines and completion of risk assessments; however, we were not provided with evidence of these audits for wards at Goole.
Although an action plan had been developed to harmonise NRC systems and processes with those of the trust, audit arrangements did not yet mirror those in other parts of the trust. For example, the ward assurance tool the ‘Adult Nursing Audit Dashboard’ and matron observational audit were used to monitor standards of patient care on ward 3 but not on the NRC.

Managers told us that the ward assurance tool process was being redeveloped as part of the Trust’s Improving Together and has now been approved by the Trust’s senior nursing team; the implementation roll out plan is currently being developed. The ACN told us that they were aware of a lack of senior nursing support at GDH and there was ongoing recruitment to help address this.

Managers at the NRC told us the service was working hard to ensure it was properly embedded into the NLaG governance structure, although it used many of the trust policies and procedures, before becoming part of the trust, so the transfer was relatively straightforward.

However, we found that arrangements for specific pharmacy support for and for obtaining agency staff with specialist skills for the NRC were not in place ahead of the move to the trust. Managers told us this had resulted in some staffing challenges in covering shifts as the previous contract was not continued. Managers told us that although pharmacy provision was under review, no arrangements for pharmacy support for the NRC had been put in place to date.

Since becoming part of NLaG, the NRC began using a number of HR systems to manage staffing, including e-rostering, a training matrix, and the nursing bank for both registered and unregistered staff. Managers reported positive feedback from staff who liked the systems for the ease of checking shift patterns and requesting training and annual leave. Trust staff had also worked with the NRC to develop a bespoke training matrix for the team, when they became part of the trust.

Management of risk, issues and performance

We reviewed the medicine risk register, which contained 61 risks. All risks had been reviewed several times throughout 2017 however many risks had little information in the way of updates and simply stated ‘risk reviewed, to remain on register’. For example, there was no recent comment or progress recorded for an action initiated in 2016 regarding level of medical cover required at GDH. There was an undated action comment that ‘Goole HLHF have put forward a proposal to implement ‘sub-acute admissions criteria’. However, this appeared to have been entered at the time the risk was registered and this did not assure us that actions regarding risks were effectively overseen or communicated to the reviewer.

The trust had a business continuity and strategy policy. This document contained details about how the trust would respond to an incident or event which could disrupt services and contained details of the key individuals to support staff.

In addition, there was also a trust major incident plan. This was in date and contained appropriate guidance, contacts and level of escalation based on risk.

We spoke with the senior managers for the medical service who told us about their main concerns / risks. These included medical and nurse staffing and staff engagement / changing culture, compliance with training and remodelling of services / pathways. Mitigating actions were explained, for example for staffing this included recruitment and retention plans / strategies, alternative staffing models and escalation plans.

During our inspection, we discussed arrangements for identifying and escalating risks, with managers. There was a risk register for the trust communities and therapies division and NRC managers described being able to add issues to the register and discuss with senior managers at the trust. There were three risks logged on the register for the NRC; medical vacancy, nurse...
staffing and the call bell system. These risks reflected the concerns shared with us by managers and staff.

**Information management**

Data provided by the trust showed that 79% of nursing staff at GDH had completed information governance training. This was below the trust target of 85%. However, medical staff were well below the trust target with 66% compliance trust wide. The trust did not provide separate training data for medical/dental staff at GDH as this was collected as part of the SGH submission.

Computers were available on medical wards; staff could access policies and clinical guidelines via the trusts intranet. We did not have any concerns about the security of patients’ records at this inspection.

The trust had electronic systems in place for staff to request clinical tests for patients and view reports and x-rays.

Staff used paper records and the electronic patient board / record (WebV) to record patient information. National Early Warning Scores were recorded on WebV, which provided reminders to staff when observations were due.

NRC staff told us they had received good support from NLaG in implementing the electronic NEWS system (WebV), wards were able to customise forms and development plans were in place for referrals management. A recent report to the trust board indicated a review of patient documentation was underway at the time of inspection, to ensure it was tailored to the needs of individual patients.

**Engagement**

We saw that the ACN had held engagement events for ward managers to develop objectives for nursing and for matrons to discuss their current role and vision for the future. Following the ward manager event, it had been agreed to hold a series of events over a year for staff nurses and HCA’s to look at their working day, the stressors, the celebrations and how they are feeling and how they can be engaged to enjoy their work.

Matrons and ward managers agreed a focus on three key areas; having a reputation within the group for being really good at fundamental nursing care, with a focus on NEWS / Care rounds / Sepsis; improving staff health and wellbeing and making education and training meaningful and up to date within clinical areas. Information was submitted to the wards to understand what these 3 areas meant to the ward staff, what would they want to see, how would they want to be involved?

The engagement activities demonstrated that the ACN was working to instil her view that ‘Caring for our patients is dependent on caring for our staff’.

A report to the NLag Board noted that NRC staff had worked to raise the profile of the service since joining the trust, working with the communications’ team to develop a new brochure, articles in the staff magazine and on the intranet. A number of “all Consultant” e-mails had been circulated and a grand round presentation was made, which had resulted in a greater number of appropriate referrals from Scunthorpe and Grimsby Hospitals. NRC leadership team had also engaged with local stakeholders across the wider Yorkshire and Humber region and the major trauma centre at Hull. The NRC team reported positive feedback on becoming integrated with the back-up and expertise provided by the trust, although there was some frustration at the slow pace of change.
Some staff at GDH were also concerned about isolation and having a voice.

The service participated in the friends and family test and CQC Inpatient survey.

The trust participated in ‘Way Forward’ public engagement events in partnership with North East Lincolnshire Clinical Commissioning Group and other health and social care providers, to share their ideas about services for the years ahead. These events had been held at each of the three hospitals over the last 18 months and provided information about national, regional and local developments in health and care and the CCG’s commissioning intentions for 2018.

The Trust gave information about the progress that had been made around improving quality, performance, finance and emergency care. There was a choice of discussion groups for patients / the public to attend to look in more detail at specific health and social topics and have your say. A consultant from the haematology service facilitated one of the groups in March 2018.

The CCG and Trust Patient Advice and Liaison teams were also at these events to listen to any complaints, compliments or any enquires about health and care services. Feedback from the events was mixed with attendees finding the sessions informative but not enough time to give opinions and suggestions, a feeling that service developments had already been decided and future sessions needed to be clearer about what the public could contribute. Members of the medical management team also attended the local health scrutiny meetings.

GDH had a patient forum which met monthly. A standard agenda was used, linked to the Care Quality Commission’s (CQC’s) key lines of enquiry and meetings were recorded. We reviewed the minutes from April 2018 where five patients attended. At the meeting, patients were introduced to a new staff member and were updated on the locked door policy and actions to address issues with the call bell system and a faulty door. Patients were briefed about the forthcoming CQC visit and reassured to ask staff if unsure about any unknown faces on the ward. Patients asked to give their view about whether the service was safe, effective, caring, responsive and well-led. Patients agreed that it was, although raised some concerns about showers and menus. Patients made suggestions for social activities and made plans to celebrate with a take-away for their last night, when a patient was going home.

Staff on both wards told us they were proud of the patient care they delivered at GDH and many staff had worked at the site for a long time. Staff told us they took part in regular team meetings and felt listened to by their managers.

Ward 3 staff had recently taken part in a trust-wide awareness day, dressing up in pyjamas and engaging with patients and families to promote the benefits of getting up and dressed, to prevent pressure area damage.

**Learning, continuous improvement and innovation**

The NRC had completed initial planning to become involved in two external research projects, for example a brain-computer interface project led by the University of Ulster. The NRC lead consultant contributed to national working parties, for example in relation to prolonged disorders of consciousness, working with the Royal Hospital of Neuro-disability in Putney.
Surgical services are provided at all three hospital sites, providing 228 beds and 10 high observation beds (HOBs) over 14 wards:

**Goole and District Hospital** – 14 beds
- Ward 7 (day surgery) – 13 chairs
- Ward 6 – 14 beds

At Goole and District Hospital there are three theatres including one day case theatre.

*(Source: Acute Routine Provider Information Request (RPIR) – AC1 Context)*

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

*(Source: Hospital Episode Statistics)*

### Is the service safe?

#### Mandatory training

During the inspections, the majority of staff we spoke with informed us that they were up to date with their mandatory training. Some staff told us that it was difficult to find sufficient time in their working day to complete mandatory training. The training courses consisted of classroom-based and e-learning.

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses February 2017 to January 2018 for medical and dental staff is shown below:

**Goole and District Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>3</td>
<td>5</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>2</td>
<td>5</td>
<td>40%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The overall mandatory training completion rate for medical and dental staff in surgery was 87.5% at Goole and District Hospital. This was above the trust target of 85%.

At Goole and District Hospital the target was met in seven out of 10 training modules.

A breakdown of compliance for mandatory courses February 2017 to January 2018 for qualified nursing and midwifery staff is shown below:

Goole and District Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>37</td>
<td>38</td>
<td>97%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>35</td>
<td>38</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>32</td>
<td>38</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>30</td>
<td>37</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>30</td>
<td>37</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>30</td>
<td>38</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>30</td>
<td>38</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>29</td>
<td>37</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>26</td>
<td>38</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>24</td>
<td>37</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for nursing and midwifery staff in surgery was 80.6% at Goole and District Hospital. This was below the trust target of 85%.

The trust target was met in two out of ten modules at Goole and District Hospital.

(Source: Routine Provider Information Request (RPIR) – P40 – Statutory and Mandatory Training)

Newly recruited staff completed most of their mandatory training at an induction programme called ‘Care Camp’. This was an intensive two-week education programme to ensure that all staff received the same training and had been operating since 2015.

The trust had a monitoring system in place on the intranet which operated a traffic light system and sent staff and managers reminder emails when mandatory courses were due for renewal.

Safeguarding

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses February 2017 to January 2018 for medical and dental staff is shown below:

Goole and District Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>3</td>
<td>5</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
The overall safeguarding training completion rate for medical and dental staff in surgery was 66.7% at Goole and District Hospital. This was below the trust target of 85%.

A breakdown of compliance for safeguarding courses February 2017 to January 2018 for nursing and midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>31</td>
<td>38</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>30</td>
<td>38</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>27</td>
<td>38</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training completion rate for nursing and midwifery staff in surgery was 77.2% at Goole and District Hospital. This was below the trust target of 85%.

Staff we spoke with were aware of when to raise a safeguarding alert and also how they would raise such an alert. Staff informed us they would inform a senior nurse in charge if they had any safeguarding concerns and also inform the trust’s safeguarding team.

The majority of staff had completed safeguarding training for adults and children to level two, with one member of staff having completed level three.

Staff we spoke with were aware that they could access the safeguarding policy on the intranet.

**Cleanliness, infection control and hygiene**

The trust had an infection control policy in place. Staff completed infection control training as part of their mandatory training.

We observed staff wearing standard NHS uniforms and staff were bare below the elbows. Aprons, gloves and antibacterial gels dispensers were available throughout the ward. There was signage near the ward entrances encouraging visitors to use the antibacterial hand gels.

The wards we visited were visibly clean and tidy. We saw cleaning in progress during our inspections. Most of the equipment had ‘I am clean’ labels attached documenting the time and date they were last cleaned.

**Environment and equipment**

The theatres we visited were visibly clean with surgical and resuscitation equipment fit for purpose and checked regularly in line with professional guidance. The theatres contained separate bins for clinical and domestic waste. The bins were clearly labelled with the types of waste that could be disposed within them.

The wards we visited were visibly clean and tidy and free from clutter; however, on ward six bays 28 – 31 had dirty marks on the floor during both the announced and unannounced inspections.

The day rooms we observed were visibly clean and tidy with chairs neatly lined against the wall.
so there was no trip hazard. The dirty utility rooms we observed were visibly clean and tidy with equipment neatly stored against the wall or on shelves thus there was no trip hazard. The cleaning cupboards were locked with equipment inside stored neatly on shelves.

The majority of the equipment on both wards had undergone safety testing recently and this was evidenced with test stickers displaying the date of test on each piece of equipment. However, we found that some equipment such as the dishwasher in the staff kitchen on ward seven and the sluice in the dirty utility room did not contain safety testing stickers. Also, there was a fire blanket on the wall that was last serviced in November 2014. This could pose a risk to patients in the event of a fire on the ward as there was a danger that the fire blanket may not be adequate.

The resuscitation trollies on both wards were examined and they were sealed with tamper proof tags that were numbered. The trollies were examined on a daily basis by staff and this was evidenced with signed and dated checklists on the top of each trolley. Inside the trollies, the defibrillators had been tested recently. This was evidenced with test stickers on the outside with date of tests. A random examination of equipment inside the trollies showed that none of it was out of date.

We reviewed the logbook for the induction machine used in anaesthesia; this had a start date of 6 March 2017. All the entries showed that the circuits were changed weekly. This was in line with the trust’s policy and national guidance.

**Assessing and responding to patient risk**

We examined 16 sets of patient records to verify whether the five steps to safer surgery including the World Health Organisation (WHO) safety checklist was being implemented consistently within surgical services. The majority of these records contained completed WHO checklists. We observed the WHO checklists being completed during our inspection of the theatres.

During the unannounced inspection, there were two patients flagged on the electronic patient records as being at risk of sepsis. The registered nurse we spoke with was aware of the sepsis pathway and explained clearly when they would complete the sepsis screening tool. At the time of our inspections there were no patients on the ward using the sepsis tool or pathway.

The wards could access emergency blood from the theatre blood bank. In relation to this, there were clear protocols for staff to follow dated 2017. Both registered nurses we spoke with on the ward knew of the protocols and could clearly explain how they would access blood in an emergency.

The patient records we reviewed showed that the trust was using the national early warning score (NEWS) tool. The trust had been an early adopter of the NEWS pathway to improve safety and clinical outcomes. We examined six patient records on the electronic patient record and all six records contained NEWS data and these were escalated and reported in line with the trust’s policy.

Patient records that we examined contained completed pre-assessment documentation that were appropriate and in line with national guidance. We found completed and signed consent forms, theatre care plans, post-operative observations and venous thromboembolism assessments.

**Nurse staffing**

The wards clearly had staffing numbers displayed on the walls which showed the number of staff planned for each shift and the actual number of staff working on each staff. This showed numbers for registered nurses and healthcare assistants.
The trust reported their registered nursing and midwifery staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goole and District Hospital</td>
<td>28.9</td>
<td>26.8</td>
<td>28.7</td>
<td>25.8</td>
</tr>
</tbody>
</table>

The trust had a fill rate of 96.1% for nursing and midwifery staff in surgery in January 2018. For the previous year (January 2017) the trust had a nursing and midwifery staff fill rate of 93.3%.

**Vacancy rates**

Annual vacancy rates for nursing and midwifery staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE as at January 2018)</th>
<th>Total number of staff establishment (WTE as at January 2018)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goole and District Hospital</td>
<td>2.0</td>
<td>26.8</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

The trust had an overall annual vacancy rate of 15.5% for all nursing and midwifery staff in surgery, which was above the trust's target vacancy rate of 6.3%.

Please note, while the figures for January 2018 show the trust to be meeting the target at all sites, the annual rate is calculated over the 12 month reporting period.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Annual turnover rates for nursing and midwifery staff in surgery from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goole and District Hospital</td>
<td>2</td>
<td>23.7</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

The trust had an annual turnover rate of 8.6% for all nursing and midwifery staff in surgery, which was lower than the trust's target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Sickness rates for nursing and midwifery staff in surgery from January 2017 to December 2017 are shown below, by site.
The trust had an annual sickness rate of 4.4% for all nursing and midwifery staff in surgery, which was higher than the trust’s target of 4.1%. Goole and District Hospital did not meet the trust target for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

The nursing bank and agency staff usage is shown below:

**Goole and District Hospital**

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Agency</th>
<th>Bank</th>
<th>Not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>0 (0%)</td>
<td>21 (28.0%)</td>
<td>16 (21.3%)</td>
<td>75</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>84 (10.5%)</td>
<td>282 (35.2%)</td>
<td>66 (8.2%)</td>
<td>802</td>
</tr>
</tbody>
</table>

At Goole and District Hospital there was a total of 387 nursing shifts filled by bank or agency staff in surgery, which represented 44.1% of all available shifts and 9.4% of all shifts remained unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

All the wards had the correct number of staff on duty that they had planned for each shift; i.e. morning, afternoon and nights. Some wards used bank and agency staff due to a lack of permanent staff. This was evidenced by the display of planned and actual staff numbers on boards in the wards. The information was for registered nurses and healthcare assistants.

Staff we spoke with felt there were enough staff on duty at any given time.

**Medical staffing**

The trust reported their medical and dental staff numbers as below, as of January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goole and District Hospital</td>
<td>11.1</td>
<td>8.5</td>
<td>9.2</td>
<td>8.2</td>
</tr>
</tbody>
</table>

**Vacancy rates**

Annual vacancy rates for medical and dental staff in surgery from February 2017 to January 2018 are shown below.
Goole and District Hospital 2.55 8.5 13.3%

The trust had an overall annual vacancy rate of 24.7% for medical and dental staff in surgery, which was above the trust’s target vacancy rate of 6.3%. Goole and District Hospital did not meet the trust’s target for vacancy rate.

Please note, while the figures for January 2018 show the trust to be meeting the target at all sites, the annual rate is calculated over the 12 month reporting period.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Annual turnover rates for medical and dental staff in surgery from February 2017 to January 2018 are shown below.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goole and District Hospital</td>
<td>0</td>
<td>5.2</td>
<td>0 %</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Sickness rates for medical and dental staff in surgery from January 2017 to December 2017 are shown below.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goole District Hospital</td>
<td>12.0</td>
<td>1,825.0</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

The trust had an annual sickness rate of 2.6% for medical and dental staff in surgery (across all sites). The sickness rate for Goole and District Hospital was 0.7%. Both were lower than the trust’s sickness target of 4.1%.

Bank and locum staff usage

The bank and agency staff usage shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>694</td>
<td>1,786</td>
<td>14</td>
</tr>
</tbody>
</table>
In surgery, from February 2017 to January 2018, a total of 694 medical and dental shifts were filled by bank staff and 1,786 shifts were filled by locum staff. There were 14 shifts that remained unfilled.

The trust did not provide the total medical and dental shifts available; therefore, bank and locum usage could not be calculated at site level.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As of October 2017, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average.

Staffing skill mix for the whole time equivalent staff working at Northern Lincolnshire and Goole NHS Foundation Trust

<table>
<thead>
<tr>
<th>Staffing Skill Mix</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle Career</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

A consultant was available onsite at Goole and District Hospital until 8pm when operating. A resident medical officer provided cover during out of hours. Staff we spoke with told us they had no concerns regarding availability of medical staffing as they responded promptly.

Records

We examined 16 patients’ records. These showed that nursing documentation and risk assessments were not always complete. On the whole the patient records were not always fully complete; for example, one record did not contain a signature on the moving and handling assessment and the MRSA screen result had not been documented. This record also did not contain a formal assessment of pressure ulcers or skin viability.

Other records did not contain completed skin viability information and the theatre care plan was not fully completed as dates and signatures were missing. One record was missing safeguarding and other assessments.

Medicines
On ward six, we examined four medicine administration records and these were completed in line with professional standards and the trust policy. However, one patient record had a medicine that was not signed for and there was no omitted dose reason entered in the record.

On ward six the drugs fridge temperature recording sheet showed that the daily readings in May were within 2 – 8 degrees Celsius range. At the end of the month the recording sheet was scanned and sent to the ward manager. The child and adult anaphylaxis boxes were tagged and dated. These were restocked by the pharmacy.

The controlled drugs ordering book was examined. This showed that drugs ordered and supplied were accurately recorded with all entries signed and dated in accordance with the trust’s medicine management policy.

The stock levels and balances recorded tallied with the number of drugs. The recording and ordering books were stored securely to prevent fraudulent use. However, there were no specimen signatures as evidence in order books. On the day case unit, the controlled drugs had not been examined for the 13 days prior to our inspection. This could pose a risk to patients in that some of the drugs may have expired.

On ward six the intravenous fluids were unlocked as were the needles and syringes. This posed a safety risk to children visiting the ward or patients lacking capacity.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported one incident classified as a never event for surgery. The never event was classified as a wrong implant/prosthesis and occurred at Diana, Princess of Wales Hospital in July 2015.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 30 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from March 2017 to February 2018. Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with seven (23.3% of all incidents)
- Pressure ulcer meeting SI criteria with five (16.7% of all incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with five (16.7% of all incidents)
Site specific information can be found below:

- Goole and District Hospital: one incident

(Source: Strategic Executive Information System (STEIS))

The trust had an electronic reporting system in place and staff we spoke with could confidently describe how they would report incidents by completing the online system. Staff we spoke with informed us they would also report the incident verbally to a senior nurse or the ward manager. All members of staff had the authority to report incidents.

The trust had an incident reporting policy which staff could access through the intranet. This policy set out the types of incidents, reporting procedures and responsibilities of managers with regard to reporting and investigation.

Most staff we spoke with could not recollect any recent incidents that they had reported. This was evidenced by the fact that one member of staff had reported an incident regarding a fall and one member of staff reported a fall three months ago.

Only one member of staff we spoke with could recollect the top two incidents for their ward; i.e. falls and pressure sores.

Staff we spoke with informed us that learning from incidents on some wards was shared by communicating at a safety briefing in the morning and staff individually reflecting upon incidents in their own time. On other wards, staff informed us that they inserted their email address on to the online reporting system in order to receive feedback once an incident had been investigated. Additionally, learning from incidents was shared by printing the lessons in to a file which staff could read and reflect upon in their own time. This file was kept in the ward manager’s office.

Staff we spoke with could accurately describe never events by giving examples such as wrong drug or wrong blood type being administered to patients and that duty of candour was being transparent and owning up to mistakes by informing patients, line managers and patients’ next of kin if they lacked capacity.
Safety thermometer

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 62 new pressure ulcers, 16 falls with harm and 20 new urinary tract infections in patients with a catheter (CUTIs) from December 2016 to December 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Northern Lincolnshire and Goole NHS Foundation Trust

Prevalence rates of pressure ulcers remained similar over time except in September when a higher proportion of patients were reported to have a new pressure ulcer. Although prevalence rates of falls with harm and CUTIs varied over time, the numbers of reported incidents were low so any differences over time may not reflect changes in patient care.

(Source: NHS Digital)

The safety thermometer data was displayed on noticeboards on the wards. These dashboards showed the number of pressure ulcers, fall and patient misidentifications. These were updated the second Wednesday of every month. We examined the boards and found them to be displaying the most recent information with the member of staff that had updated the board and
the date of the last update.

The information on the dashboards was collected by sisters and other senior nursing staff. The data was discussed at team meetings and these were held consistently on a monthly basis.

**Is the service effective?**

**Evidence-based care and treatment**

Policies were stored on the intranet and staff we spoke with explained how they could access these policies.

Staff we spoke with were aware of the sepsis pathway and explained clearly when they would complete the sepsis screening tool. The sepsis screening tool and pathway were based on national guidance.

**Nutrition and hydration**

Staff we spoke with informed us that patients could be referred to a dietitian if there was a need.

Protected meal times were in place and during our inspection we observed that patients were provided with their meals on time. Drinks were provided at meal times and in between meals. We saw that drinks were placed within patients’ reach.

We examined five fluid balance charts and noted that one wasn’t completed fully; the chart was difficult to interpret as it did not document the total figures.

Prior to surgery, patients were given information leaflets which advised them clearly on fasting times for food and fluid prior to surgery.

**Pain relief**

Medical records examined showed that patients were administered pain relief drugs. This was clearly documented with signatures and dates. Staff monitored the effectiveness of the pain relief drugs by asking patients about their pain at regular intervals.

Staff used pain management plans to effectively manage pain relief of patients. The majority of the patient records we reviewed contained completed pain scores.

Patients we spoke with were satisfied with the way staff responded quickly in dealing with their pain.

**Patient outcomes**

**Goole & District Hospital (Acute)**

From November 2016 to October 2017, all patients at Goole and District Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

All of the top three elective specialties at the hospital, based on count of activity (urology, ophthalmology and trauma and orthopaedics), had a lower expected risk of readmission when compared to the England average.

There was no activity for non-elective admissions at this hospital.
Elective Admissions - Goole & District Hospital (Acute)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was worse for EQ VAS outcomes and about the same for EQ-5D index outcomes.

For hip replacements and knee replacements was about the same as the England average.

(Source: NHS Digital)

Competent staff

As well as completing the mandatory training, staff had the opportunity to complete additional
training such as equipment training, PREVENT training and a diploma or undergraduate degree. Staff told us that managers were supported if they identified a course that they wanted to complete which would be beneficial to their career development. There were link nurses available on the wards; for example, an infection prevention and control link nurse.

**Appraisal rates**

From April 2017 to January 2018 65.7% of staff within surgery at the trust had received an appraisal compared to a trust target of 95%.

A split by staff group can be seen in the table below:

**Goole and District Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>5</td>
<td>5</td>
<td>95%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic,</td>
<td>3</td>
<td>3</td>
<td>95%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Technician Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>14</td>
<td>15</td>
<td>95%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>9</td>
<td>11</td>
<td>95%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>12</td>
<td>28</td>
<td>95%</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

Goole and District Hospital had an appraisal completion rate of 69.4% which did not meet the trust’s target. Two staff groups met the 95% appraisal target with 100% appraisal completion.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

All the nursing and healthcare staff we spoke with had yearly appraisals, with some having completed this in December 2017 and a couple of staff were due to have their appraisal in the next couple of months. Staff we spoke with informed us that they found the appraisals beneficial as they enabled them to identify their accomplishments and focus on their objectives for the future.

All the staff we spoke with stated that they did not have regular formal supervision. Instead they could talk to their line managers as and when needed as they were always visible and approachable.

Newly recruited staff completed an induction programme called ‘Care Camp’. This was an intensive two-week education programme to ensure that all staff received the same training and had been operating since 2015.

**Multidisciplinary working and coordinated care pathways**

There were multidisciplinary team (MDT) meetings held to discuss patients on specific pathways. These meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists.

The wards had access to occupational therapy and physiotherapy over six or seven days a week.
Staff we spoke with informed us that all colleagues irrespective of grade worked together effectively and supported each other.

**Seven day services**

The hospital had access to occupational therapy six days a week and to physiotherapy seven days a week. The hospital used nurse and therapy led discharge to try and reduce the hospital length of stay.

**Health promotion**

Health promotion information was available on all wards we visited. This included display boards and information leaflets. Staff we spoke with informed us that patients could utilise support groups such as smoking cessation, drugs and alcohol services and housing needs.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards. We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

The Mental Capacity act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, were someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests.

Staff we spoke with informed us that they had completed Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) training either as part of their mandatory training or separately upon commencing their role.

We spoke with eight members of staff across two surgical wards. All the staff were knowledgeable what they would do if they came across a patient lacking capacity.

Deprivation of Liberty Safeguards (DoLS) can only be used if a person will be deprived of their liberty in a care home or a hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards.

There were no DoLS patients on any of the wards that we visited.

**Is the service caring?**

**Compassionate care**

We observed staff speaking with patients in a polite and friendly manner. At mealtimes, staff ensured that the food and drinks were placed within easy reach of the patients and no visitors were on the ward to ensure that patients could eat their meals without disturbance.

We spoke with 14 patients and two visitors during our inspection. The majority of the patients were satisfied with the level and type of care they were receiving. Patients we spoke with informed us that all staff were very friendly and they were kept informed about any changes to their care plans. One patient we spoke with stated “excellent care, really good, everybody cares”.

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Another patient we spoke with said “they felt safe and the nursing staff on the ward were kind and attentive”.

**Friends and Family test performance**

The Friends and Family test (FFT) response rate for surgery at Northern Lincolnshire and Goole NHS Foundation Trust from December 2016 to November 2017 was 23% which was worse than the England average of 29%. A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at Northern Lincolnshire and Goole NHS Foundation Trust, by site.**

![Graph showing response rates](image)

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Ann. Perf.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goole &amp; District Hospital</td>
<td>243</td>
<td>10%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>856</td>
<td>32%</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Diana, Princess Of Wales Hospital</td>
<td>1,460</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

Patients we spoke with told us they had not waited long from admission to the hospital to their actual admittance to the theatre.

Patients we spoke with told us that nursing staff had introduced themselves and we saw whiteboards displaying details of staff on duty that day. People informed us that their privacy and
dignity had been respected. This was evidenced with staff making appropriate use of curtains to ensure that patients were covered.

Three patients we spoke with told us they were impressed at how quickly they had been admitted to the ward. One person stated, “they couldn’t believe it had been so quick”. They explained that they had received two letters on the same day, one for pre-admission clinic and one giving the date for the procedure.

**Emotional support**

A multi-faith chaplaincy service was available for patients to access during their stay. Staff from the chaplaincy team could visit patients on the wards to provide emotional and spiritual support. A multi-faith prayer room was located on the ground floor of the hospital.

We observed that ward managers and senior nursing staff were visible on the wards and that patients and relatives could speak to them if they had any concerns.

The service had access to psychological and counselling support. This could be accessed through the nursing staff.

**Understanding and involvement of patients and those close to them**

Patients and relatives, we spoke with told us that staff involved them in their care decisions. This included asking them about their full medical history, including allergies and staff informing them about the risks and benefits of their surgery.

Patients we spoke with told us that staff answered their questions fully and explained things in simple language so that it was easy to understand.

One patient told us their surgery was scheduled for next week but it was brought forward to account for their holiday.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The hospital provided elective surgical treatments for patients.

Patients were seen at pre-assessment appointments where they were assessed whether they were suitable to be treated at Goole and District Hospital.

The trust was in the process of increasing the utilisation of the hospital by introducing additional orthopaedic patients to Goole and District Hospital.

**Meeting people’s individual needs**

The trust had access to interpretation services. Staff had a telephone provided by a company which they plugged in to their telephony system and dialled through to the interpretation service. Upon connection, the company put the patient through to an interpreter who provided interpretation over the telephone. Staff we spoke with informed us that they could also request interpreters to attend the hospital in person. Staff we spoke with were competent and confident in accessing these services.
Staff we spoke with informed us that people with learning disabilities usually brought their own carer to the hospital to assist them in communicating with the nursing and medical staff. Patients with dementia were referred to the dementia specialist nurses for support during their time at the hospital.

The hospital had a multi-faith prayer room located on the ground and also a chaplaincy service which provided spiritual support to patients. The chaplaincy team could visit patients on the wards.

**Access and flow**

Patients were given appointments at a time that suited them and people were kept informed about the time they had to wait for their treatment. The hospital was accommodating to people’s needs; for example, a patient had their surgery scheduled in a week's time, but it was brought forward to accommodate their holiday. Two patients we spoke with told us they had been offered ‘cancellation’ slots to have their surgery on the day of inspection.

**Average length of stay**

**Elective Average Length of Stay - Goole & District Hospital (Acute)**

![Elective Average Length of Stay Chart]

*Note: Top three specialties for specific trust based on count of activity.*

**Goole & District Hospital (Acute) - elective patients**

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

Trauma and orthopaedics had an average length of stay for non-elective patients of 6.5 days which was lower than the England average of 8.8 days.

**Non-Elective Average Length of Stay - Goole & District Hospital (Acute)**

![Non-Elective Average Length of Stay Chart]

*Note: Top three specialties for specific trust based on count of activity.*
Referral to treatment (percentage within 18 weeks) - admitted performance

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was generally slightly lower than the England average. Over the 12 month period the trust’s performance ranged from 61% to 69% and in the most recent month (December 2017) the 65% of patients were treated within 18 weeks from time of referral which was lower than the England average of 72%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of RTT rates for surgery broken down by specialty is below. Of these five specialties were above the England average:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>80.9%</td>
<td>76.9%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>72.9%</td>
<td>64.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>58.0%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>52.3%</td>
<td>61.4%</td>
</tr>
</tbody>
</table>

Four specialties were below the England average

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>70.1%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>61.1%</td>
<td>72.3%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From January 2016 to December 2017 the percentage of patients whose operation was cancelled and were not treated within 28 days increased over time, but in six out of eight quarters the trust performed better than the England average. In the most recent quarter (Q3 2017/18) 5% of patients whose operation was cancelled were not treated within 28 days.
From January 2016 to December 2017 the percentage of cancelled operations at the trust improved from Q3 2016/17 to Q4 2016/17 before deteriorating for the remaining reporting period. The trust generally performed similar to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

Summary of complaints

Goole and District Hospital

From 7 February 2017 to 7 February 2018 there were four complaints about surgery at Goole and District Hospital.

The trust took an average of 57 working days to investigate and close complaints. The trust has three targets for closing complaints. The trust has a target to close complaints within 30 working days and a further target of 45 working days. Only 50% of all closed complaints in surgery were closed in 30 working days and 50% of closed complaints were closed within 45 working days.

The trust has a target to close more complex complaints within 60 working days. Of all closed
complaints (complex and non-complex) 100% were closed within this target.

The subjects complained about at this hospital for surgery was patient care with five complaints (71.4%).

Is the service well-led?

Leadership

Leaders attended the aspiring managers’ course and leadership course. In addition, they attended the clinical skills course on a weekly basis at Goole and District Hospital.

Staff we spoke with told us the associate chief nurse was approachable and visible and staff felt supported by this availability.

Staff we spoke with felt supported by their managers and colleagues at ward level. They felt supported by the matrons and divisional managers as they were visible on the ward and had an open door policy in their offices, so that staff could approach them at any time with any issues or concerns. The matron held monthly supervision with staff that they directly managed and they were also available to contact via telephone in between supervision sessions.

All the staff that we spoke to informed us that leaders at board level were not visible at Goole and District Hospital. They had only seen them at their induction.

Vision and strategy

The trust had a mission statement but this had not been developed in consultation with staff, no member of staff we spoke with could recollect this mission statement.

The majority of staff that we spoke to were not aware of the strategic plan for the surgical division. The trust’s values were displayed on posters throughout the ward, however, only one member of staff out of eight we spoke with was able to tell us what the trust’s values were.

Culture

Staff we spoke with said they said they felt valued by their patients, ward leaders and the trust and had not witnessed or experienced bullying or harassment. Staff told us if they witnessed or experienced bullying or harassment, they would either confront the perpetrator or inform their line manager.

Staff we spoke with enjoyed working on the surgical wards as they felt supported by their colleagues and line managers. One staff member told us “I love my job and I love orthopaedics”.

Two out of the eight staff we spoke with had heard of the trust’s pride and respect project and could name the trust’s freedom to speak up guardian.

Governance

The directorate had changing governance structures. The divisional clinical director was a member of the trust management board and although a new structure, the management team felt that this had improved communication within the directorate. The directorate had also set up a surgical management board which was attended by all clinical leads and the senior management team said this had a greater degree of clinical focus. Each speciality had business meetings
which escalated issues of concern to the overall surgical business meeting.

The current governance structures were in their infancy within the directorate and currently provided low-levels of assurance against safety performance, from board to ward. The surgical management team acknowledged that governance needed to be strengthened within the directorate especially oversight of mortality, they also acknowledged that they required a further period of embedding to be fully effective.

The surgical directorate transformation plans were based on the getting it right first time (GIRFT) methodology, this is a programme to improve efficiencies and clinical quality in the NHS, by reducing variations. Transformation boards and meetings had been developed within all specialities. Minutes we reviewed from these meetings showed that key actions had been identified and these issues had been rated, however from reviewing the plans and meeting minutes we did not see oversight of all recovery plans, or discussion of the current number of patients awaiting appointments or clinical validation. Following the inspection, the senior management team said that this oversight was at the business meetings and surgical board meeting.

The service had ward meetings attended by all nursing and healthcare assistant staff. However, ward managers informed us that these weren't always held monthly and not all staff attended on a regular basis. A quality and safety day was held regularly which was attended by matrons for both surgical and critical care.

Ward managers’ meetings were held with staff from Goole and District Hospital, Scunthorpe General Hospital and Diana Princess of Wales Hospital attending as well as matrons and the associate chief nurse. At these meetings, the action plans agreed upon previously were reviewed as well as approving the minutes from the previous meetings.

Monthly site meetings were held at Goole and District Hospital which were attended by ward managers.

Management of risk, issues and performance

The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services.

The service monitored performance and this was evidenced through a ward audit dashboard which contained rated scores for various elements of care delivery such as cleanliness and infection control for the last three months, prior to inspection, the audit dashboard showed that the different areas on the whole achieved a score of 95% or over.

The directorate also monitored performance by collecting data on areas such as theatre optimisation; i.e. planned versus actual, theatre utilisation, elective cancelled operations on the day, and elective cancelled operations on the day for non-clinical reasons. In April 2018, the hospital introduced ward dashboards for deteriorating patients.

The hospital held monthly surgery and critical care clinical governance group meetings which had an agenda and were minuted. The current governance structures were in their infancy within the directorate and currently provided low-levels of assurance against safety performance, from board to ward. The surgical management team acknowledged that governance needed to be strengthened within the directorate especially oversight of mortality, they also acknowledged that they required a further period of embedding to be fully effective.

At the 2016 inspection, we said that the trust must ensure that service risk registers are regularly reviewed, updated and include all relevant risks to the service. The surgical division had a risk
register which highlighted current risks and documented mitigating actions to reduce the risks. The risks were reviewed regularly at team meetings and updated accordingly. We discussed with senior staff within the surgery division about their highest risks, they identified staffing, performance, capacity, finance and pressure area management as the highest risks. This correlated with what other members of staff at lower levels on the wards informed us.

However, staff we spoke with were not sure about divisional risks, where the risk register was stored and how they could add risks to this register.

**Information management**

The trust stored patient records electronically and as hard copies. Staff could access the patient records using an online system which was password protected and staff had different levels of access according to their grades. Nurses could access blood tests results for patients through the electronic system whereas doctors and consultants could access x-ray and scan results through this same system.

**Engagement**

Staff we spoke with felt valued by their ward and the trust as a whole. Staff were encouraged to develop professionally by being supported to complete training courses additional to mandatory training.

Patients were given information about support groups such as smoking cessation, drugs and alcohol, housing needs etc.

Patients were provided with information leaflets on topics such as blood transfusion, Parkinson’s disease. The leaflets were in English and staff informed us they would contact the Patient Advice and Liaison Service (PALS) for leaflets in other languages.

Staff we spoke with told us that they were consulted at team meetings in relation to changes to services. There weren’t many changes that had been implemented that affected patients, hence they had not been involved in any consultation.

**Learning, continuous improvement and innovation**

The surgical division had an online reporting system for incidents. Staff completed the online form and could tick a box to receive lessons learned upon completion of the investigation. Additionally, the lessons learned were printed and kept in a folder that was stored in the matron’s office. Staff could read these lessons learned in their own time for their self-reflection.
Northern Lincolnshire and Goole NHS Foundation Trust provide a range of maternity services for women at three acute hospital sites: Diana, Princess of Wales Hospital, Scunthorpe General Hospital, and Goole and District Hospital.

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

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

Community midwives work flexibly across services, offering antenatal and postnatal care in clinics at Goole District Hospital, GP practices, children’s centres, and in women’s homes.

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

From October 2016 to September 2017 there were 4,194 deliveries at the trust.

A comparison between the number of deliveries at the trust and the national totals during this period is shown below.

A profile of all deliveries and gestation periods from July 2016 to June 2017 can be seen in the tables below:
Table 1: Profile of all deliveries (October 2016 to September 2017)

<table>
<thead>
<tr>
<th>NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4,130</td>
</tr>
<tr>
<td>Multiple</td>
<td>64</td>
</tr>
<tr>
<td>Mother's age</td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>240</td>
</tr>
<tr>
<td>20-34</td>
<td>3,398</td>
</tr>
<tr>
<td>35-39</td>
<td>473</td>
</tr>
<tr>
<td>40+</td>
<td>83</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,194</td>
</tr>
</tbody>
</table>

Notes: A single birth includes any delivery where there is no indication of a multiple birth.

Comparatively more woman under 20 years of age (5.7%) and between the ages of 20 and 34 years (81%) gave birth at the trust compared to England averages; 3.1% and 75.1% respectively.

Table 2: Gestation periods (October 2016 to September 2017)

<table>
<thead>
<tr>
<th>NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Gestation period</td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>*</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>240</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>3,272</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>*</td>
</tr>
<tr>
<td>Total number of deliveries with a valid gestation period recorded</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3,518</td>
</tr>
</tbody>
</table>

Notes: To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with "*" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The gestation period of babies born at term (between 37 and 42 weeks) was 93.3%, which was above the England national average (91.8%).

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.
We saw evidence of a decline in the number of women delivering at the midwife-led unit at Goole District Hospital. There had been a re-design of the birthing pool room in 2015, which resulted in limited availability between October 2014 and June 2015. Data gathered during our last inspection showed that between October 2014 and September 2015 the total number of births was 19. During our most recent visit, senior staff reported that only three women had delivered at the unit from March 2017 to April 2018.

Data received from the trust showed that from April 2017 to March 2018, the home delivery rate for Scunthorpe and Goole Hospitals was 2.2% of total births across the locality. This was within the trust’s target threshold (of 2.2% and higher).

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Maternity services offered at Goole District Hospital were midwife-led. A consultant obstetric clinic ran one morning per week, comprised of 0.2 whole time equivalent medical staff. Therefore, we do not report on mandatory training compliance for medical staff at this location.

The community midwife manager for Goole and Scunthorpe managed the mandatory training of community midwifery staff. Staff were allocated to training as required, and if unable to attend, the session was rearranged.

There are three teams of community midwives within the wider Scunthorpe and Goole team, who provided services across the local area. A breakdown of compliance for mandatory courses from February 2017 to January 2018 for qualified Scunthorpe and Goole community midwives is shown below:
Scunthorpe and Goole community midwives:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>22</td>
<td>22</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>20</td>
<td>22</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>18</td>
<td>22</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>18</td>
<td>22</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>18</td>
<td>22</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>17</td>
<td>22</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>17</td>
<td>22</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>17</td>
<td>22</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>13</td>
<td>22</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>11</td>
<td>22</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>171</td>
<td>220</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for Scunthorpe and Goole community midwifery staff was 78%. This was below the trust target of 85%.

Scunthorpe and Goole community midwives exceeded trust completion targets for ‘manual handling – object’ (100%) and ‘resuscitation’ (91%) training. Completion targets fell slightly short of target for ‘conflict resolution’, ‘manual handling – people’, and ‘slips, trips and falls’ training (at 82% each).

We noted the low completion rate for ‘infection control – level 1’ training, which stood at 59%.

During our inspection, we inspected the training record of a midwife leading an antenatal and a postnatal clinic at the midwife-led unit. We found the staff member was 93% compliant with mandatory training. We noted that ‘infection control – level 1 training was outstanding, but that this was due to be completed shortly.

Staff described that infection control training could be completed online or by using a workbook. If a workbook was used, this required registering completion with a member of staff at the trust responsible for updating the learning management system. Staff told us that this caused delays in the accurate reflection of training records.

Information received from the trust showed that 44 of 48 community midwives (92%) had completed ‘infection control – level 1’ training in the previous financial year (April 2016 to April 2017). This included 21 of 23 community midwives at Scunthorpe and Goole (91%).

Mandatory training for staff working in maternity services should include neonatal and obstetric emergencies training as a minimum (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

Midwives were required to complete obstetric emergency skills and drills training. These took place at Scunthorpe General Hospital. Senior staff at the midwifery-led unit explained that the training was responsive to incidents and potential risks.

In September 2017, community midwives working at the unit had taken part in an emergency pool evacuation drill. Previous skills and drills training had focused on post-partum haemorrhage, shoulder dystocia, and third and fourth degree tears. A senior member of staff with responsibility for the midwife-led unit said that she was planning a training drill to place in a staff member’s
home, to simulate an emergency in the community.

The trust provided updated (year to date) mandatory training compliance data in March 2018 for maternity specific staff groups. This showed the overall proportion of staff within designated groups that had completed applicable maternity specific mandatory training modules (a maximum of 26 training courses).

Data showed training compliance for Scunthorpe and Goole community midwives was 75% overall. Course specific compliance rates for staff at different sites were not provided.

Midwifery staff told us that they attended an annual obstetric skills and drills training session. Data provided by the trust in May 2018 showed compliance for skills and drills training across sites was 81% for maternity services staff. Site specific data was not provided.

We saw that skills and drills training had taken place for antepartum haemorrhage, postpartum haemorrhage, cord prolapse, eclampsia, shoulder dystocia, and vaginal breech. Compliance rates ranged from 80% to 83% for each emergency training module.

We spoke to the trust’s governance midwife who explained that the figures did not include ad-hoc emergency study days; and if included, the compliance rate would be considerably higher.

During our inspection, we saw the obstetric emergency study day schedule for 2018. There was a schedule specific to Scunthorpe General Hospital, which Scunthorpe and Goole community midwives attended. The information included monthly dates for skills and drills training to December 2018.

Senior staff at the unit described that midwifery staff participated in obstetric ALERT (Acute Life-threatening Events Recognition and Treatment) training alongside medical staff, such as anaesthetists and obstetricians. The training was a one-day multi-professional course to train staff in recognising deteriorating pregnant women and to act appropriately. Staff we spoke with told us the training took place annually. There was a requirement to complete training every four years.

Data we received from the trust showed 81% compliance for ‘modified early warning scores (MEWS) and recognition of the severely ill patient’ training for applicable staff within maternity services across sites.

Compliance for new born life support (NLS) training, for applicable staff within maternity services and across the trust locations was 70%.

Senior community staff told us that all community midwives at the trust had undertaken additional ‘baby lifeline’ training focussed on childbirth emergencies in the community. An external provider facilitated the training in Manchester. There were two cohorts of community midwives, and training had taken place in December 2017 and March 2018. The training was multidisciplinary and completed alongside ambulance crews.

We saw 99% compliance for fetal (CTG) monitoring training for applicable staff within maternity services across sites. K2 training had achieved 89% compliance. During our visit, senior staff told us that a ‘masterclass’ was to take place in July 2018, which would capture those that had not yet attended, and increase this rate.

Safeguarding
The safeguarding policy had a review date of June 2017 and therefore had not been updated. There was an up to date domestic abuse policy (due for renewal May 2019). A named individual at the trust had oversight of the policy register. We looked at the register and saw appropriate
actions were in place for maternity specific documents that had expired or were approaching their review date. (Please refer to the effective section, evidence based practice section of the report.)

There was a safeguarding midwife in post at Goole District Hospital. The midwife worked in antenatal and postnatal clinics running at the site; and received protected time for monitoring and managing safeguard issues and enquiries. The safeguarding midwife held a monthly meeting with a local health visitor and social worker on site, in which safeguarding issues were discussed.

Safeguarding midwives at the trust attended child protection conferences and other external multidisciplinary safeguarding meetings. The safeguarding lead for the trust told us that audits were currently being carried out to monitor attendance.

Staff we spoke with knew the safeguarding reporting procedures and safeguarding themes commonly encountered. For example, those centred on substance abuse and domestic violence.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. The safeguarding lead told us that safeguarding training was a priority for the trust.

Maternity services offered at Goole District Hospital were midwife-led. A consultant obstetric clinic ran one morning per week, comprised of 0.2 whole time equivalent medical staff. Therefore, we do not report on safeguarding training compliance for medical staff.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for Scunthorpe and Goole community midwives is presented below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>21</td>
<td>22</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>21</td>
<td>22</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>20</td>
<td>22</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>18</td>
<td>22</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall safeguarding training compliance rate was 91% among Scunthorpe and Goole midwives. Completion targets for safeguarding children training (level 1, 2 and 3) were surpassed. The completion target for safeguarding adults training (level 1) fell slightly short of target at 82%.

**Cleanliness, infection control and hygiene**

We observed hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks with hand washing technique signs. Hand gels were located at entrances with signs encouraging their use, and throughout clinical areas.

We saw staff washing their hands and using hand gel between patients, as appropriate. All staff we met adhered to arms bare below elbows guidance.
Personal protective equipment (PPE) was available in all areas we visited and provided to staff in the community.

The birthing room and clinic were visually clean. We inspected a cleaning schedule of the birth unit that showed regular cleaning of the unit and flushing of water outlets was undertaken. The schedule had been fully completed for the period reviewed (from 02 October 2017 to the date of our visit). There was an infection, prevention and control flowchart displayed that showed birthing pool filling and cleaning procedures.

We inspected the store room at the birthing unit, which was found to be orderly, clean and tidy.

There had been no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within maternity services at the trust in the last 12 months.

In the 2017 CQC maternity survey, the trust scored 9.0 out of a possible 10 for the cleanliness of rooms and wards; this was similar to the England average.

**Environment and equipment**

The midwife-led birth unit had a non-clinical feel, and staff explained that further work was underway to make the unit feel more homely. For example, we saw a large tree mural had been added in the entrance hall. Staff described plans to add pictures of babies born at the unit to the mural.

There was a separate family room / waiting area within the birth unit, which had several large comfortable chairs and a settee. A television with MP3 and DVD access was available, as were beverage making facilities, a toaster, and a refrigerator.

The birthing room itself was light and airy and housed a large birthing pool. There was adequate equipment in the birth room to meet patients’ needs. This included a variety of equipment for women to use in labour, for example, a birthing ball, birthing stool, and TENS machine.

The midwife led unit had a separate digital locked entrance and the environment in the maternity unit was secure.

Staff at the unit told us that out of hours access to the birthing unit had changed since our last inspection. On 04 April 2018, the minor injuries unit at Goole District Hospital passed to an independent provider, and direct out of hours access to the birthing unit was no longer available. Under the new arrangement, a community midwife would meet the woman at home and to check she was in established labour. If so, an additional midwife would be called. The midwives would then call hospital security to advise them of their arrival. The two midwives would then accompany the woman to the birthing unit, meeting the security guard on duty to gain access to the building.

The trust provided us with a flow chart entitled ‘Goole Midwives out of hours process’, which outlined the new access protocol. The flow chart was appended to, and reflected and referenced in, the Goole Midwifery Suite Guidelines (June 2018).

In the birthing room, there was an easily accessible net stored on the wall, for use when evacuating a woman from the pool in an emergency.

We checked neonatal resuscitation equipment held at the birth unit. We found the equipment reviewed was within date, and weekly checklists fully completed from 16 July 2017 to the date of our visit, with the exception of the week commencing 25 September 2017.
We found the adult resuscitation equipment reviewed was within date, and weekly checklists fully completed from 31 December 2017 to the date of our visit. If needed, the unit was able to access the adult resuscitation trolley on ward 3 (a medical ward), which was located a little further along the main hospital corridor.

The trust provided us with audit data of monthly resuscitation trolley checks from March 2017 to March 2018. Data showed 100% compliance at trust level over the period.

The post-partum haemorrhage emergency equipment we reviewed onsite was all within date. Weekly checklists were fully completed from 25 October 2017 to the date of our visit, with the exception of the week commencing 12 March 2018.

We saw that the adult per-arrest drugs box, anaphylaxis adult and child drug box, and adult cardiac arrest drug box were all appropriately sealed and within date.

We inspected the antenatal and postnatal clinic areas and found that they had a welcoming atmosphere. There was clear signage throughout the clinic, and patient areas were clean and bright. Magazines and information booklets were available, and a radio was playing in the background. There was children’s play area to the side of the waiting area.

Equipment cleaning assurance labels provide assurance that re-usable patient equipment is clean and ready for use. We saw that labels were available and used appropriately across clinical areas.

The ‘Notification of Home Birth / Goole Suite Delivery’ form (review date October 2020) was a document completed by community midwives during antenatal visits. The form contained a section that included review of what equipment (if any) was available at the woman’s home, and what additional equipment the attending midwife needed to take along for delivery.

Midwives had access to the equipment they would use for a home birth, in line with their guidelines: Goole Midwifery Suite Guidelines (June 2018) and Home Birth Guidelines (review date November 2020).

Community midwifery staff told us and we saw that they checked and signed each shift to show they had checked the equipment they had used, and were competent to use it. This included bariatric scales, and portable suction.

The sample of portable electrical equipment inspected across the unit and in the community was all tested and in date, with the exception of sonicade fetal dopplers (used for monitoring fetal heart rate). Staff at the unit and in the community told us that the dopplers did not require electrical testing. However, the trust provided data that showed that a small selection of sonicade dopplers had been tested at two locations (at other trust sites) from 2016 to 2018.

Assessing and responding to patient risk

We reviewed the Goole Midwifery Suite Guidelines. The guideline had an expiry date of March 2018. During our visit we saw a revised version (May 2018) due to be submitted to the Obstetrics and Gynaecology Governance Group. Following our inspection, the trust provided a final version approved 01 June 2018.

The guideline provided guidance for staff when managing women who requested a birth in the suite. It contained information about the type and frequency of antenatal risk assessments, admittance criteria, and escalation and transfer procedures. There were associated guidelines for ‘Midwifery Led Care’ (review date June 2019) and a ‘Homebirth Guideline’ (review date
Staff we spoke with in the clinic said that antenatal risk assessments were carried out for all expectant mothers. We reviewed eight sets of patient records held at the clinic and found good documentation of medical, social and mental health assessments. Assessments were completed in all cases, with the exception of a mental health assessment for one of the eight women. Care pathways (including changes to the care pathway) were clearly documented in all of the eight records we reviewed.

A serious incident had occurred in community midwifery services at the trust in the 12 months prior to our inspection. The investigation found that the correct schedule and frequency of antenatal appointments was undertaken. In addition, that the woman had been correctly identified as ‘high risk’ and had received consultant input. Learning from the serious incident included enhanced review and escalation procedures for higher risk women wanting to birth in the community.

We reviewed the Goole Midwifery Suite Guidelines (June 2018), which detailed the amended procedure for higher risk women who persist in requests for delivery at the unit or at home, against medical advice. Procedures described referral to an obstetrician, discussion of risks with the woman, clear documentation of risks, and completion and dissemination of an enhanced birthplan (to matron, central delivery suite coordinator (Scunthorpe General Hospital) and all community teams). The guidelines referred to the notification of social workers, where the family already had one home birth against medical advice. Changes to the procedure were reflected in the recently revised ‘Homebirth Guideline’ (review date November 2020).

For both guidelines, there was a list of indicators for transfer of women and these included maternal request, and concerns regarding foetal or maternal wellbeing.

Both guidelines were used in conjunction with stand-alone documents. The ‘Home Birth / Goole Discussion Checklist’ (review date October 2020) was a checklist used for confirming antenatal discussions with women requesting a home / midwife-led unit birth. It also contained a discussion checklist of possible reasons for transfer. Individual items needed to be signed and dated by the midwife, and the woman needed to sign and date the document to confirm items had been discussed. The ‘Notification of Home Birth / Goole Suite Delivery’ form (review date October 2020) also required midwives document any risks identified from the woman’s notes, and whether a consultant review was needed.

Where women needed consultant-led care and transfer from the midwife led unit/ deviation from the ‘Home Birth Pathway’ (issue date December 2017), there was an appropriate transfer procedure in place.

The trust provided a flow chart entitled ‘Goole Midwives out of hours process’, which outlined actions to take if a woman required emergency intervention. The flow chart was appended to and referenced in the Goole Midwifery Suite Guidelines (June 2018). Actions comprised the midwife initiating an emergency bleep call, the cardiac arrest team led by the resident medical officer (RMO) attending the patient, the midwife initiating an emergency (999) call for an ambulance, and making security aware of ambulance arrival. Staff were able to confirm the procedure.

There was a poster on the wall in the birth unit that detailed emergency transfer procedures. We also saw emergency bleep numbers displayed for the delivery coordinator and night coordinator at Scunthorpe General Hospital.

Data we reviewed showed 91% of Scunthorpe and Goole community midwives had completed mandatory ‘resuscitation’ training. In addition, all community midwives at the trust had undertaken additional ‘baby lifeline’ training focussed on childbirth emergencies in the community between December 2017 and March 2018.
In the birthing room, there was an easily accessible net stored on the wall, used to evacuate a woman from the pool in an emergency. We did not see a birthing pool evacuation procedure / flow chart in the room. We informed staff, who told us they would rectify this. Staff were, however, able to show us an in-date policy document (Labour and or Delivery in Water), which contained emergency pool evacuation guidance. Staff described that they and other community midwives had received emergency pool evacuation skills and drills training in September 2017.

Midwifery staff identified women at high risk by using an early warning assessment tool, known as the maternity early warning score (MEWS). This was to assess the health and wellbeing of women identified as being at risk. The assessment tool enabled staff to identify and respond with additional medical support where needed. All eight records we inspected on site contained appropriately completed MEWS tools.

We also identified risk assessment (SBAR) forms, fluid balance charts, ‘fresh eyes’ on intrapartum records and CTG, and swab count following perineal repair recorded and completed, as applicable, in all eight records reviewed.

Senior staff told us that of the three births at the midwifery-led unit in the previous year, there had been one emergency transfer. There was no maternity dashboard data as evidence of the number of transfers. However, additional data provided by the trust confirmed the birth and transfer rate.

**Midwifery and nurse staffing**

The midwifery-led unit was staffed by community midwives. During labour, women at the unit and in the community received two midwives to one women care.

We found a mixed picture of staffing within the Scunthorpe and Goole community midwifery team.

Birthrate plus had been implemented in 2017 as a strategic workforce planning tool. Senior community midwifery staff we spoke with explained that implementation of the tool had resulted in fewer community midwives, and the introduction of more administrative staff within the team.

Data provided by the trust showed that from February 2017 to January 2018, the establishment level of whole time equivalent (WTE) community midwifery staff had fallen from 19.38 to 16.21 within the Scunthorpe and Goole community midwifery team.

Over the same period, the WTE vacancy midwife rate within the team fell from 1.8% (0.35 WTE vacancies) to 17.4% over-establishment (2.82 WTE over the new establishment level of 16.21 WTE staff).

However, data provided by the trust showed that from April 2017 to March 2018, the average community caseload within the Scunthorpe and Goole community team was 143 women per midwife. The current recommended Birthrate plus ratio, allowing for some changes in allowances and the NICE Guidance since 2009, is 96 cases per WTE midwife.

Data about bank and agency staff usage and panned versus actual staffing for the Scunthorpe and Goole community midwifery team were not provided.

On-call community midwives for the location consisted of two midwives each night. All calls went through the central delivery suite at Scunthorpe General Hospital and staff reported cross-site team working to address staffing shortfalls, particularly at Scunthorpe General Hospital.
Escalation procedures were in place to move midwives between sites, including calling on community midwives to support the central delivery suite at Scunthorpe District Hospital.

Staffing at Scunthorpe General Hospital (ward 26 and the central delivery suite) was added to the maternity risk register in December 2016 as presenting a high risk; and downgraded to moderate in November 2017.

The ‘Home Birth / Goole Discussion Checklist’ (review date October 2020) contained a checklist to ensure that women understood a homebirth might not be possible due to unforeseen circumstances. Circumstances included several homebirths happening at once, severe weather, sudden sickness of midwife, and excessive workload on the maternity unit at Scunthorpe.

We saw some evidence to suggest that ongoing sickness absence in the Scunthorpe and Goole community team had sometimes meant that a homebirth service was not available.

Staff we spoke with at the midwifery-led unit and in the community told us that staffing shortfalls were reported as incidents. We reviewed maternity incident data from September 2017 to December 2017 and saw evidence of four staffing incidents concerning shortfalls of community midwifery staff. All four incidents concerned women who had booked for homebirth, but who were advised to attend hospital because only one community midwife was on duty. Where indicated, staff shortages related to sickness absence.

We reviewed staff sickness data submitted by the trust and found that there was a 14.5% sickness rate in the Scunthorpe and Goole community midwifery team in November 2017 and a 10.6% sickness rate in December 2017. In the months of January 2018 and February 2018, the sickness rate ranged between 1.6% to 3.8% and was within trust target (4.1%).

An update about nursing, midwifery and care staffing capacity and capability was presented to the Board on 27 March 2018. The update detailed that sickness levels in community midwifery needed to be monitored to ensure cover could be provided. The report did not specify which community midwifery team (if one in particular) this referred to.

Red Flag maternity staffing guidance was published by NICE in February 2015, and highlights signs that may indicate there are not enough midwives available; for example, a delay of two hours or more between a woman coming in for induction of labour and the process being started.

From February 2018 to May 2018, 12 red flags were reported at Scunthorpe and Goole hospitals. In three cases, escalation procedures were followed and community midwives were called upon to support services at Scunthorpe General Hospital. A separate red flag incident, which was not dated on the records received, showed suspension of the homebirth service due to no on-call community staff being available.

**Medical staffing**

A consultant held an obstetric clinic one morning per week at the midwifery-led unit. Women were risk assessed throughout their pregnancy to assist with the decision as to the safest place to give birth. The clinic was for those women who met high risk criteria and needed consultant led care.

The trust provided their medical staff numbers within maternity services at Goole District Hospital, and provided their current position figure for January 2018. Data showed that a dedicated (0.2 whole time equivalent, WTE) member of medical staff had been in place since December 2017.

Annual vacancy rates for medical staff in maternity services at Goole District Hospital showed a 1.8 vacancy rate from February 2017 to January 2018. When compared to the annual number of WTE medical staff (2.2), this equated to an annual vacancy rate of 81.7% over the period.
However, there were no medical vacancies at the time of the inspection; the vacancy had been permanently filled since December 2017.

Bank and locum staff usage and annual turnover and sickness rates for medical staff in maternity services at Goole District Hospital were not provided.

**Records**

We saw secure storage facilities for records at the midwife-led unit. Electronic records were also kept, and procedures for safe storage were in line with data protection requirements.

Handheld notes were carried by women throughout pregnancy, in line with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) statement 3.

We reviewed eight sets of patient records held at the midwifery-led unit. We found that a risk assessment for obstetric / medical history and social history were carried out in all cases. A risk assessment for mental health history had been documented in seven out of eight cases. Staff told us that the notes of mothers identified as ‘higher risk’ were kept in the clinic for consultant review and follow-up. Care pathways (including changes to care pathways) were clearly documented in all of the eight records we reviewed.

Where applicable, we found intrapartum documentation fully completed in all eight records reviewed. This included documentation of risk assessments (using SBAR forms), modified early warning scores (MEWS), and the use of ‘fresh eyes’.

Maternal post-delivery documentation was also found to be fully completed in applicable case notes reviewed. This included handover (using SBAR), risk assessment, correct plotting of MEWS and escalation where appropriate, and discharge to community midwifery care.

**Medicines**

The hospital pharmacist was responsible for routine checking and monitoring of medicines in the midwifery-led unit. Medicines were stored correctly, which included emergency medicines and we found appropriate checks had been carried out.

We saw that the adult per-arrest drugs box, anaphylaxis adult and child drug box, and adult cardiac arrest drug box were all appropriately sealed and within date.

Oxygen was available in the birthing room and we found it stored correctly.

Medicines held by community midwives (such as oxytocics, used after delivery) were appropriately stored; and staff said the hospital pharmacist replaced them every six weeks. Medicines for homebirths were prescribed directly to the mother by their GP.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, no never events had occurred in maternity services at Goole District Hospital or in community midwifery services at the trust.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in maternity services that met the reporting criteria set by NHS England from March 2017 to February 2018.

A breakdown of the incident types is shown below:

- Seven maternity/obstetric incident meeting SI criteria: mother only (59% of total incidents).
- Three maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) (25% of total incidents).
- One abuse/alleged abuse of adult patient by staff (8% of total incidents).
- One sub-optimal care of the deteriorating patient meeting SI criteria (8% of total incidents).

Seven of the 12 incidents occurred at Diana, Princess of Wales Hospital, four at Scunthorpe General Hospital and one was reported in the community.

The serious incident reported in the community involved staff in the Scunthorpe and Goole community midwifery team. We reviewed the completed serious incident investigation report, which identified areas of good practice and areas of concern, contributory factors and recommendations.

We saw evidence the serious incident investigation was regularly reviewed in Obstetrics and Gynaecology Clinical Governance Meeting minutes (January to March 2018). Root cause analysis identified key learning outcomes. At the time of our inspection, we saw that enhanced birth plans for higher risk women who insist on home delivery against medical advice, and a review of the trust’s homebirth and induction of labour guidelines had been completed. An ongoing action plan had been implemented and learning shared across the service.

Incidents were reported on an electronic system. All staff we spoke with at the midwifery-led unit and in the community were aware of how to report incidents and gave examples of the types of things they would report.

Staff we spoke with at the midwifery-led unit reported that learning from serious incidents was gained through monthly team meetings and weekly newsletters; which were displayed on the wall and kept in the ‘learning lessons folder’ in the staff office. The ‘learning lessons folder’ contained a one-page summary sheet for each completed serious incident investigation within maternity services at the trust. These were compiled and circulated by the Governance Midwife.

Staff we spoke with were aware of the serious incident that had occurred in the community and reiterated findings and learning points from the investigation. The community midwifery manager had provided ongoing family liaison and care following the incident.

Senior staff we spoke to were not aware of any incidents that had occurred at the midwifery-led unit in the 12 months prior to our visit, and described a limited number of incidents that had occurred in the community.

We reviewed data for maternity incidents that had occurred at the trust from January 2017 to January 2018 and were submitted to the National Reporting and Learning System (NRLS). We narrowed data by speciality to community midwifery. Excluding the serious incident already discussed, data showed 53 incidents were reported during this period. Most concerned incidents...
that had occurred in hospital-based maternity services, which affected community midwifery practice. For example, a patient being discharged from hospital after delivery, but temporarily lost to community services due to an error in discharge paperwork. Most incidents were categorised as relating to ‘access, admission, transfer, discharge (including missing patient)’ (12 or 23%), ‘clinical assessment (including diagnosis, scans, tests, assessments)’ (12 or 23%), or ‘documentation (including electronic & paper records, identification and drug charts)’ (10 or 19%). Four incidents recorded an outcome of low harm and 49 incidents were recorded as resulting in no harm.

When we discussed incidents with senior community midwifery staff, they gave examples of incidents investigated. Examples included the non-reporting of positive antibody screens. These were among the four ‘low harm’ incidents captured on NRLS from January 2017 to January 2018.

The Duty of Candour (DoC) is a legal duty for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that had led to moderate or significant harm. Duty of candour was evidenced in the completed serious incident investigation and meeting minutes we reviewed. The staff we spoke with at the midwifery-led unit said they were open and honest with women if things went wrong.

**Safety thermometer**

During our 2016 inspection of maternity services at the trust, we recommended the trust begin to upload data to the maternity safety thermometer. The trust had submitted this data since January 2017.

The Maternity Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but the service can change this. Data must be submitted within 10 days of suggested data collection date. The graphs below identify the levels of harm free care for the maternity service at the trust.
The graphs show mixed results for the perception of harm free care for the service; however, women reported feeling safe 100% of the time between August 2017 and February 2018.

**Is the service effective?**

**Evidence-based care and treatment**

The delivery of care and treatment provided to women was based on guidance issued by professional and expert bodies. This included the National Institute for Clinical Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), Nursing and Midwifery Council (NMC), and evidence based practice.

Staff at the midwifery-led unit and in the community told us that policies and guidance could be accessed on the trust intranet, which they found easy to navigate. We checked 16 policies; with the exception of two, which were being reviewed, they were current and reflected quality standards and national guidance.

The minutes of the Obstetrics and Gynaecology Governance Group showed monitoring of controlled documents within the services. Document Control Percentages reported in March 2018 showed 97% compliance for clinical documentation and 99% for guidelines.

The manually held policies and clinical guidelines we saw at the midwifery-led unit were seen to be within date with version control.
During the inspection, we saw a centrally held document control register. The register listed all trust policies and clinical guidelines; alongside version controls, review dates, and the different stages of review (where applicable). A named individual at the trust had oversight of the register. The governance midwife informed us that a maternity specific document register was emailed to them each month. From this, they were able to have oversight of documents approaching a review date and take necessary action to ensure they were reviewed and revised.

We looked at the maternity specific document register. We saw appropriate actions were in place for maternity specific documents that had expired or were approaching their review date. For example, named individual staff were listed against policies currently being reviewed together with a date for submission for approval.

**Nutrition and hydration**

Refreshment facilities were available in antenatal clinic waiting area. Women and their families had access to kitchen facilities at the midwifery-led unit to make snacks and hot and cold drinks. The kitchen was equipped with microwaves to warm food brought in externally.

Monday to Friday there was a dining area within the hospital and shop where women and visitors to the service could access food and drinks.

The UNICEF initiative is a worldwide programme that encourages maternity hospitals to support women to breastfeed. UNICEF BFI professional officers inspected in October 2017 and re-accredited the service with full UNICEF baby friendly accreditation, level 2.

Trust-wide breastfeeding initiation rates for deliveries that took place in hospital from March 2017 to April 2018, showed an average of 68.2%. This was lower than the trust’s target rate of 74.4%, but the same as the Yorkshire and Humber average of 68.2%.

Maternity dashboard figures showed the breastfeeding initiation rates combined for Goole District Hospital and Scunthorpe General Hospital. The data showed an average breastfeeding initiation rate of 64.5% from April 2017 to March 2018.

Breast-feeding information leaflets and posters were displayed in patient areas.

There was a dedicated infant feeding team at the trust, with a remit to provide support services across the locality. The service was open to referrals from any health and social care professional, and women could self-refer. There was an infant feeding lead in post for Scunthorpe and Goole hospitals. Infant feeding team members provided support for mothers in hospital and community settings, and in women’s own homes.

**Pain relief**

Pain relief was available and this included Entonox, tens machine and use of the birthing pool.

During our inspection, there were no women in the midwife-led unit so we could not confirm how effective pain management was; nor we able to speak to a post-natal woman who had birthed there or in the community.

**Patient outcomes**

There was an audit programme across maternity services. Monthly measures included compliance with obstetric early warning scores, intrapartum fresh eyes, swab counts, resuscitation trolley checks, and the WHO five steps to safer surgery checklist. Data was
presented at trust level.

The table below shows the proportions of deliveries at the trust from October to September 2017, recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
<th>England (n=607,089)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections1</td>
<td>982</td>
<td>23.4%</td>
</tr>
<tr>
<td>Instrumental deliveries2</td>
<td>351</td>
<td>8.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries3</td>
<td>2,850</td>
<td>68.0%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>11</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,194</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans  
²Includes forceps and ventouse (vacuum) deliveries  
³Includes breech and normal (non-assisted) deliveries

The trust had a higher rate of non-interventional deliveries than the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The trust maternity dashboard showed the proportion of women who had a non-interventional delivery had increased from 67.5% in quarter two, to 70.3% in quarter three of 2017-2018. This was better than the Yorkshire and Humber average of 64.8%.

Maternity dashboard data for Scunthorpe and Goole hospitals showed from April 2017 to March 2018, the non-assisted delivery rate was 66.0% and the assisted delivery rate was 4.2%.

Maternity active outlier alerts

As of January 2018, the trust has no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Data about patient outcomes at the service showed a mixed picture. There were comparatively low rates of large postpartum haemorrhage and third and fourth degree tears for deliveries at Scunthorpe and Goole Hospitals. In addition, the stillbirth rate at Scunthorpe and Goole Hospitals was below the trust target threshold, and an MBRRACE action plan was in place.

However, there were relatively high proportions of babies born before 37 weeks gestation, and babies born with a low birth weight at term compared to regional averages. This might be associated with the comparatively high proportion of women smoking at time of booking and at time of delivery in the locality. Both smoking status measures were higher than regional averages and approximately double the targets set by the trust (see health promotion).

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)
The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.5. This was based on data collected from January 2015 to December 2015 (the most recent available at the time of inspection).

This is up to 10% higher than the average for the comparator group rate of 5.2, which indicates their performance was worse than expected.

(Source: MBRRACE UK)

The trust provided us with a MBRRACE Perinatal Mortality Surveillance Report action plan, compiled between July 2017 and November 2017. The plan comprised 16 actions, which included, increased screening, better provision of multidisciplinary training in situational awareness and human factors, clearer pathways for women who present with reduced fetal movements, and multidisciplinary management of women with diabetes.

Maternity dashboard data showed that from April 2017 to March 2018, the stillbirth rate total (per 1000 births) at Scunthorpe and Goole hospitals was 4.13. This was better than the trust target threshold of 4.7.

Maternity dashboard data for Scunthorpe and Goole hospitals showed that from April 2017 to March 2018, the number of babies born less than 37 weeks gestation was 9.8%, and the number of babies born with a low birth weight at term was 2.4%.

There were no trust targets (thresholds) for baby gestation or birthweight at term displayed on the maternity dashboard. However, rates appeared higher than regional averages. As comparators, 7.5% of babies on average were born less than 37 weeks gestation in the Yorkshire and Humber region in quarter three of 2017 to 2018; and an average of 0.9% were born with a low birth weight at term over this period.

Maternity dashboard data for Scunthorpe and Goole hospitals showed that from April 2017 to March 2018, the proportion of women who had a normal delivery and experienced a third or fourth degree tear was 1.3%.

There were no trust targets (thresholds) for third or fourth degree tears displayed on the maternity dashboard. However, the rate for normal delivery appeared similar to the regional average. For example, the Yorkshire and Humber average for quarter three of 2017-2018 was 2.1%.

Maternity dashboard data for Scunthorpe and Goole hospitals showed that from April 2017 to March 2018, the proportion of women who had experienced a postpartum haemorrhage of greater than 1500mls was 1.7%.

There were no trust targets (thresholds) for postpartum haemorrhage displayed on the maternity dashboard. However, the rate was lower than the regional average. As a comparator, 2.8% of women had an experienced a postpartum haemorrhage of greater than 1500mls within the Yorkshire and the Humber region in quarter three of 2017 to 2018.

Senior staff told us that of the three births at the midwifery-led unit from March 2017 to April 2018, there had been one emergency transfer (equating to a transfer rate of 33%). There was no maternity dashboard data as evidence of the number of transfers. However, additional data provided by the trust confirmed the birth and transfer rate.

Competent staff

Following our inspection in June 2017 the trust had recruited a clinical skills and patient safety
midwife. The purpose of this role was to be clinically based, highly visible, coordinate the delivery of training and ensure development of the maternity workforce. The ward managers managed the allocation of mandatory training and the Governance midwife said they had oversite.

The trust had an in date clinical supervision policy for registered nurses and midwives. Staff we spoke with told us supervision took place at least annually and was provided by professional midwives advocates; following the advocating for education and quality improvement (A-EQUIP) midwifery supervision model.

Medical staff undertook annual competency checks for their registration.

Support was provided to staff during their preceptorship period (newly qualified midwives) this included “camp care” which was a week where new staff received all IT access, and induction training. New staff were supported in theatre by the clinical skills and patient safety midwife to ensure safety was maintained.

There was a preceptorship programme to support progression for band five to band six midwives over a one to two-year period.

Appraisal rates

From April 2017 to January 2018, 73% of qualified community midwifery staff across the trust received an appraisal compared to the target of 95%. At Scunthorpe and Goole, 80% of staff received an appraisal in the same timeframe.

<table>
<thead>
<tr>
<th>Name of location / team</th>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target</th>
<th>Appraisal completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe and Goole</td>
<td>Qualified Nursing Midwifery Staff</td>
<td>20</td>
<td>16</td>
<td>95%</td>
<td>80%</td>
</tr>
</tbody>
</table>

The comparatively low number of staff within the Scunthorpe and Goole community team meant that 19 of the eligible 20 staff would need to receive an appraisal to meet the compliance target. As of January 2018, an additional three staff were required to complete an appraisal to meet the compliance target.

Community midwives were trained in postnatal ‘check up’s’ and new-born and infant physical examination (NIPE). A senior community midwife told us a ‘good proportion’ of community midwives were newborn infant physical examination (NIPE) trained. However, they were unable to provide us with an exact figure. We saw an action relating to the ‘Maternity services patient safety strategy 2018-2020’ (version 4). It detailed a plan to NIPE train all community midwifery staff. This would allow women to be discharged from hospital earlier, with the proviso that new-born babies would receive a NIPE check in the community within 72 hours. The timeframe for implementation was June 2018.

Community midwives worked on-call each month and this included working at Scunthorpe General Hospital. Community midwives also rotated into the hospital for two weeks every 18 months. This helped them keep up to date with their competencies and skills.

A specialist bereavement midwife was in post, who worked across sites. There was also a consultant-led ‘rainbow clinic’. The ‘rainbow clinic’ was a specialist service for women and their
families in a subsequent pregnancy following loss. A new programme of bereavement training had been implemented, with dates offered for May and October 2018. Training was available for midwives (full-day) and healthcare assistants in midwifery services (half-day). The training schedule included monitoring, diagnosis of miscarriage, treatment of miscarriage, ectopic pregnancy, funeral arrangements following pregnancy loss, and emotional care.

Maternity services staff had been invited to attend a baby loss and bereavement care conference at St Andrew’s Hospice in August 2018.

**Multidisciplinary working**

There was a formalised structure of meetings in place to enable multidisciplinary team working. These included monthly maternity governance meetings and perinatal mortality and morbidity meetings.

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

The midwives at the unit supported weekly antenatal clinics with the consultant obstetrician.

A number of community midwives in the locality were based at children’s centres and work was aligned with primary care services. Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.

The safeguarding midwife at Goole District Hospital held a monthly onsite meeting with social workers and health visitors to discuss and take action on safeguarding concerns.

Annual emergency skills and drills training and ALERT (Acute Life-threatening Events Recognition and Treatment) training took place alongside medical (obstetric) staff. Community midwives had undertaken ‘baby lifeline’ training focussed on childbirth emergencies in the community, which involved training alongside ambulance crews.

There were clear processes in place for multidisciplinary working in the event of maternal transfer by ambulance and transfer from homebirth to hospital.

**Seven-day services**

The birthing suite and on-call community midwives were available twenty-four hours a day, seven days a week.

Midwifery-led antenatal and postnatal services at Goole District Hospital were provided from Monday to Friday. The availability of evening and weekend clinics in the community supported choice for women and those who were not able to attend during the day.

Emergency maternity and diagnostic services were available at Scunthorpe General Hospital, twenty-four hours a day, seven days a week.

**Health promotion**

There was a consultant midwife with a lead for teenage pregnancies and public health at the trust.

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in smoking cessation,
substance abuse, and infant feeding.

Maternity dashboard data provided by the trust showed the proportion of women smoking at time of booking across the trust was 20.8% in quarter three of 2017-2018. This was higher than the trust’s target rate of 11% and higher than the Yorkshire and Humber average for the period (18.4%).

The proportion of women smoking at time of delivery across the trust was 21.2% in quarter three of 2017-2018. This was higher than the trust’s target rate of 11% and higher than the Yorkshire and Humber average for the period (13.4%).

Maternity dashboard figures for Scunthorpe and Goole Hospitals showed that from April 2017 to March 2018, the proportion of women smoking at time of booking was 22.4% and the proportion of women smoking at time of delivery was 19.6%. Both rates were higher than the trust target of 11%.

Senior community midwifery staff we spoke with told us that smoking cessation clinics were available in the locality. However, that smoking rates were high as the areas covered were socio-economically deprived. As part of their MBRRACE Perinatal Mortality Surveillance Report action plan, the trust was investigating service provision across the trust for smoking cessation services, with a view to expanding provision. The report was submitted to Directorate Governance Group in April 2018.

A wide range of health promotion patient information leaflets was available in the clinic. These included, ‘Screening tests for you and your baby’, ‘Tests for dads’ (for sickle cell and thalassaemia) ‘Meningitis baby watch’, ‘Fit for Pregnancy’, ‘Why weight matters’, ‘Whooping cough and pregnancy’, and a selection of smoking cessation material.

Information about antenatal classes and support groups were also displayed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust did not provide mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training data. The Safeguarding Lead for the trust told us the MCA and DoLS training was delivered with a focus on consent to treatment.

There was a trust-wide Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) policy; which was due for renewal April 2018. There was a MCA/DoLS lead in place at the trust, who told CQC staff that a new policy had been written and was awaiting final ratification.

During our visit, a senior member of staff told us that MCA and DoLS training sessions were planned for community midwives, but that dates were not yet available.

The trust had a policy for consent to examination or treatment, with a review date of June 2017.

Staff we spoke with at the midwifery-led unit and in the community clearly articulated the use of Gillick competency for consent of patients under the age of 16 years.

Is the service caring?

Compassionate care
Friends and Family test performance

Friends and family test performance (antenatal), Northern Lincolnshire and Goole NHS Foundation Trust

From January 2017 to January 2018 the trust’s maternity friends and family test (antenatal) performance (% recommended) was in line with the England average for all months in the period aside from June and July 2017 where performance fell below the England average. The trust reported 100% recommend for three months during the period (March, May and August 2017).

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns and the trust had less than six responses in December 2017 and January 2018, which shows on the graph as 0% recommend.

Friends and family test performance (birth), Northern Lincolnshire and Goole NHS Foundation Trust

From January 2017 to January 2018 the trust’s maternity friends and family test (birth) performance (% recommended) was better than or in line with the England average, reporting 100% recommend for six months during the period (February, March, April, May, June and December 2017).

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

Friends and family test performance (postnatal community), Northern Lincolnshire and Goole NHS Foundation Trust
From January 2017 to January 2018 the trust’s maternity friends and family test (postnatal community) performance (% recommended) was generally worse than the England average. The trust reported less than six responses in four of the months in the period (February, March, April 2017 and January 2018) which show on the graph as 0% recommend.

Please note that no data for the maternity friends and family test was published by NHS England in November 2017 due to data quality concerns.

(Source: NHS England Friends and Family Test)

CQC Survey of women's experiences of maternity services 2017

The trust performed about the same as other trusts for all 19 questions in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>7.4</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>9.5</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.2</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same</td>
<td>9.3</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time</td>
<td>About the same</td>
<td>9.3</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth,</td>
<td>About the same</td>
<td>9.0</td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
<td>Score</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>were you treated with respect and dignity?</td>
<td>About the same</td>
<td>8.7</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>8.0</td>
<td></td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>6.9</td>
<td></td>
</tr>
<tr>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>About the same</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>About the same</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>8.0</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same</td>
<td>9.0</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same</td>
<td>8.2</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>About the same</td>
<td>8.4</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

A Friends and Family Test board was visible on entry to the midwifery-led clinic. Data for March 2018 showed 97% of people who responded would recommend antenatal care at the trust, and 1% would not; and 100% would recommend postnatal care in the community.

Thank you cards and examples of feedback were on display in the clinic. These were positive, thanked staff for their help and support, and included words such as “wonderful” and “fantastic”.

During our inspection, we observed women’s health unit staff speaking to patients with respect and understanding. Staff were positive about providing good quality and compassionate care to women.

The patient we spoke with at the midwifery-led unit was positive about the postnatal care they had received from the community midwives, and said that she felt “supported”.

**Emotional support**

There were guidelines and care pathways in place at the trust to support mothers and their family in the event of miscarriage, termination for fetal abnormality, stillbirth, or neonatal death.

There was a consultant-led ‘rainbow clinic’. The ‘rainbow clinic’ was a specialist service for women and their families in a subsequent pregnancy following loss; and women were able to self-refer. A specialist bereavement midwife was in post, who worked across sites.

There was an information booklet outlining options for funeral arrangements, which offered the services of the hospital chaplaincy and the support of local funeral directors, if needed. The booklet contained information about an annual baby memorial service, and a baby memorial book; held in the hospital chapel.

We saw that the trust is working with Sands (the stillbirth and neonatal death charity) to implement and test a new National Bereavement Care Pathway (NBCP) for pregnancy and baby loss. The trust implemented the pathway in April 2018, and will be working with Sands to
understand the impact of the pathway and its effectiveness in improving bereavement care for parents. Five experiences of pregnancy or baby loss are included in the pathway including miscarriage, termination of pregnancy for foetal anomaly, stillbirth, neonatal death and the sudden unexpected death of an infant up to 12 months.

‘Butterfly stickers’ were used in antenatal notes to indicate that women had previously experienced pregnancy loss and baby bereavement. Butterfly door signs were used in the hospital to indicate a current loss.

Maternity services had also introduced ‘cherished care packs’, to be given to parents following a still birth or neonatal death. There was a range of keep sake materials available for women to choose from, to suit different types of loss and different baby gestations.

Information leaflets available about baby loss and bereavement were available in clinic, including those from the Mariposa Trust, ‘4Louis’, and the ‘Blue Butterfly Support Group’. These included contact details for national charities and local support groups.

We saw very positive feedback from a family who had been cared for by Scunthorpe and Goole community midwives who had experienced a bereavement.

Understanding and involvement of patients and those close to them

The aim of the service was to work in partnership with women and their family throughout pregnancy, birth and afterwards; to offer the services and support they needed.

Midwifery staff we spoke to at the unit and in the community had good local knowledge of the women and communities they served.

In the 2017 CQC maternity survey, for being involved enough in decisions about their care during labour and birth, women scored the trust 8.9 out of 10 (which was about the same as other trusts, and an improvement on their 2015 score of 8.4).

An external provider undertook a survey of women who had recently used maternity services at the trust in September 2017. An action plan had been developed to address women’s concerns and recommendations. For each action, there was an action lead, timescale for completion (all set for August 2018) and expected evidence of completion (anticipated changes to practice and delivery).

There was a Maternity Voices Partnership in place at the trust. The partnership had a remit to enable the hospital trust and other service providers to listen to and take account of the views and experiences of maternity service users. Parents who had had a child at the trust in the last three years were invited to join and share their experiences of care. The group was comprised of local parents, commissioners, hospital, community and council staff, and chaired by a local mother. The group met every two months in Scunthorpe or Grimsby, and there was a social media page and online forum. Experiences of care could also be submitted by email.

When using the birthing facilities women were encouraged to bring their birthing partners and family with them and made welcome as part of the birth.

Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy
From Q2 2016/17 to Q3 2017/18 the bed occupancy levels for maternity were lower than the England average in all periods, with the trust having 44.1% occupancy in Q3 2017/18 compared to the England average of 58.9%.

The chart below shows the occupancy levels compared to the England average over the period.

![Chart showing occupancy levels]

(Source: NHS England)

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

Facilities were available for partners and relatives to stay and visit, during and after delivery.

During previous inspections we found that from April 2014 to March 2015, there were 30 births at the unit. There had been a re-design of the birthing pool room and as a result the birthing pool was not available between October 2014 and June 2015. Between October 2014 and September 2015, the total number of births was 19. Senior staff at Goole District Hospital told us that only three women were admitted to the midwifery-led unit between April 2017 and April 2018.

Senior staff explained that the fall in women utilising the services was due to a greater number of women who expressed an interest falling outside of admittance criteria. For example, those with a BMI of greater than 35, and those that needed inducing into labour. The member of staff also commented that the change in access arrangements might have negatively affected the number of women using the service. Two community midwives were required to attend the woman's home and then accompany the woman to the birthing suite. Women who might otherwise have used the suite might have chosen to birth at home.

Staff said that they were developing plans to attract more women to birth in the unit. These included locally advertising the services, on radio and in newspapers, and holding coffee mornings to open the unit to interested women.
Meeting people’s individual needs

Women could book their initial antenatal appointment directly, by telephone or online and did not require referral.

Women at the trust were offered the choice to deliver at home, in a midwifery-led birthing suite, or in hospital (at Scunthorpe General Hospital or Diana Princess of Wales Hospital, Grimsby). The service at Goole District Hospital aimed to provide a local midwife service for women in the Goole area.

Parent education classes were available in the community setting and information relating to labour and birth was provided at antenatal appointments.

The birthing suite afforded women the choice to deliver in a ‘home-from-home’ setting whilst receiving midwifery-led care. Women interested in birthing in the suite were invited to tour the suite and view the facilities available.

Information booklets and guidelines were available for women using the service. These included a guide to ‘Goole Midwifery Suite’ (due for renewal August 2018), which outlined the benefit and drawback of midwifery-led births, admittance criteria, and possible risks.

Across the trust, there were midwives available for support and guidance and with special interests as part of their role. These included midwives who specialised in safeguarding, teenage pregnancy, smoking cessation, substance abuse, bereavement and infant feeding.

However, staff we spoke to highlighted that there was no teenage pregnancy midwife cover for the Goole locality; and the specialist service had to be accessed at Scunthorpe General Hospital.

A face-to-face and telephone translation service was available, provided by ‘Big Word Translation’ services and British Sign Language signers. The trust had also applied ‘Browse Aloud’ to their external web pages, to enable audio capabilities for those with visual impairments. ‘Browse Aloud’ also allowed users to listen to an audio reading of web content in different languages.

There was a chapel and a prayer room at Goole District Hospital with multi-faith provision. The chaplaincy team at the trust provided an out of hours on-call service for part of the week.

There was a policy and procedure for Spiritual Care Standards in place at the trust, which outlined the importance of respecting the religion and belief of all, regardless of creed.

Access and flow

Women in the locality had good access to antenatal and postnatal care delivered at Goole District Hospital and in the community.

There were guidelines for ‘Midwifery Led Care’ (version 3.1, review date June 2019), and Goole Midwifery Suite Guidelines (June 2018). The guidelines provided guidance on which women were eligible for midwifery led care (and delivery in the midwifery-led unit), risk assessments and record keeping, and actions to take should the woman develop risk factors requiring obstetric opinion.

Women were able to book their initial antenatal appointment directly, by telephone or online, and did not require referral.

Maternity dashboard data for Scunthorpe and Goole hospitals showed that from April 2017 to March 2018 89.3% of initial antenatal bookings were undertaken before 13 weeks. This was
marginally below the trust target of 90%. For the same period, bookings within the 13 week threshold minus agreed exclusion targets (such as mothers presenting later in pregnancy) stood at 97.0%.

Staff we spoke with at the clinic told us that women who did not attend were followed up by telephone call, and through their GP surgery, if necessary.

A consultant held an obstetric clinic one morning per week at the midwifery-led unit. The clinic was for those women who met high risk criteria and needed consultant led care. This enabled women to have antenatal care closer to their home instead of attending the consultant-led clinics at Scunthorpe District Hospital or Diana Princess of Wales Hospital (Grimsby).

A weekly midwifery-led postnatal drop in clinic was held at the unit, which enabled women who might not otherwise attend to present with any issues or concerns.

Data from April 2017 to March 2018 showed the home delivery rate for Scunthorpe and Goole Hospitals was 2.2% of total births across the locality. This was within the trust’s target threshold (of 2.2% and higher).

**Learning from complaints and concerns**

**Summary of complaints**

From February 2017 to February 2018 there were 19 complaints about maternity services (4% of total complaints received by the trust).

The trust took an average of 62 working days to investigate and close complaints. This is not in line with the trust targets for closing complaints within 30 working days, or the further target of 45 working days.

The most common subjects complained about in maternity were patient care (68%) and staff values and behaviours (16%).

(Source: Provider Information Request P55)

We reviewed complaints data and found that one complaint related to maternity services at Goole District Hospital. This concerned postnatal outpatient care provided by midwifery staff. The complaint was under investigation at the time of our inspection.

There was a trust complaints policy and procedure in place, which staff we spoke with were aware of; and we saw patient advice and liaison service (PALS) information leaflets on display in the areas we visited. We also saw trust information leaflets on display in the waiting area about how to make a comment, compliment or complaint. Staff we spoke with said they would always try to resolve complaints and concerns locally when they arose, and would inform the community manager.

We reviewed monthly Obstetrics & Gynaecology Clinical Governance Meeting minutes for January, February and March 2018. These detailed PALS and complaints received by hospital site, and the number of open complaints. Data was inclusive of obstetrics and gynaecological services. Trends in complaints were identified. For example, March 2018 meeting minutes highlighted a trend in relation to delay or failure in treatment or procedure.

Staff we spoke with at the midwifery-led unit reported that learning from complaints and concerns was primarily gained through monthly community team meetings and maternity services bulletins, such as ‘lesson of the week’ and the ‘patient safety newsletter’. 
During our visit, we saw a ‘lesson of the week’ circular (dated 04 May 2018) that detailed a thematic summary of the ‘top 5 PALS/complaints’ across maternity services at the trust. Themes included communication, clinical treatment/care, staff values and behaviours, misfiling, and appointments including delays and cancellations.

We saw evidence of learning from incidents. The completed serious incident report we reviewed captured lessons learned. We saw that key recommendations, such as enhanced birth plans for higher risk women who insisted on home / midwifery-unit delivery against medical advice had been implemented.

**Is the service well-led?**

**Leadership**

Maternity and gynaecology services formed part of the Women’s and Children’s group. An associated chief operating officer (ACOO), a group clinical lead (GCL) for obstetrics and gynaecology and an interim head of midwifery (IHOM) led the service.

A non-executive director represented the service at board level. Since our previous inspection in 2016, staff reported the service had received a greater focus and scrutiny from the trust board.

The interim head of midwifery (IHOM) had been in post for eight months prior to our inspection. All staff spoke positively of the changes and progress the service had made since she had come into post.

There were two operational matrons, one covering Diana Princess of Wales Hospital and one covering Scunthorpe and Goole hospitals. A band seven community team leader managed the midwifery-led unit and the Scunthorpe and Goole community team.

**Vision and strategy**

The service had a three to five-year strategy, which included strategic objectives and an action plan to implement the strategy.

The strategy supported the implementation of better births review of maternity services. It also reviewed clinical and financial pressures and was available in the public domain.

The Women and Children’s Division Strategic Objectives 2017-20 set out maternity service’s mission “to provide safe, effective and leading-edge care to the population we cover through nurturing high performing teams that prioritise patient care”.

The vision was for “every woman and child in our locality is healthy and happy”. Five main strategic goals were stated. These included, encouraging the use of innovative ideas, and evidence based techniques and treatments; by developing midwife/specialist nurse led care, and improving diagnosis and management of ‘small for gestational age’ fetus. In addition, to have the right levels of staff, appropriately trained and delivering excellent care in a positive, compassionate environment. This meant ensuring ‘Birthrate plus’ establishment for midwifery and safe staff-to-patient ratios were maintained, and ensuring appropriate staffing levels.

There was a ‘Maternity Project Plan’ in place. At the time of viewing (May 2018), the plan contained 19 milestones and associated actions to achieve these (numbering over 120). For each, there was a named ‘owner’ responsible for implementation, a status (completed, on-track, or delayed), and a baseline finish date. Baseline-finish dates indicated that the plan had been
implemented in January 2017. We saw that 17 actions ‘required attention’, most of these were ‘on-track’, with two marked as delayed.

Senior midwifery staff said they were developing plans to attract more women to birth in the unit. These included locally advertising the services, on radio and in newspapers, and holding coffee mornings to open the unit to interested women. However, plans to publicise the service had been ongoing since our last inspection of the service. There did not appear to be a clear vision or strategy in place to encourage women to utilise the birthing suite.

**Culture**

We observed good team working, with midwives working collaboratively and with respect for each other’s roles. All staff spoke positively and was proud of the progress the service had made since our 2016 inspection of maternity services at the trust.

Evidence provided by the trust showed they had undertaken an exercise in August 2017 to identify the morale of staff. Themes included a lack of positive feedback and staff reported being valued by patients and their immediate manager but not by the trust as a whole. A follow up exercise undertaken in January 2018 showed an improved picture, where staff felt listened to and were valued.

Senior staff at the midwifery-led unit told us that the interim head of midwifery had had a positive impact on the culture within maternity services at the trust.

Midwifery staff we spoke with said that managers were supportive and approachable and they would feel confident escalating any concerns. A student midwife described she felt supported and encouraged by more senior colleagues.

**Governance**

Following our previous unannounced inspection in 2017, the service had employed a full-time governance midwife who worked across sites. Support was provided by the trust wide governance team with a governance facilitator and additional secretarial support.

The governance midwife was responsible for coordinating the training of maternity services workforce at the trust, to ensure the development and delivery of successful clinical care.

The governance midwife led on most of the incident root cause analysis (RCA) reports and they were also allocated to other staff by the triumvirate.

The service held monthly governance meetings. The group had a remit to review and approve applicable policy documents, and to ensure appropriate infrastructures and reporting arrangements were in place. They also had a responsibility to review the serious incidents, incidents, complaints, PALS, case reviews, network reviews and neonatal peer reviews within relevant departments and wards; develop action plans in response to these and share lessons learned. In addition, to review and update any relevant risks on the risk register and monitor any action plans that arise from this. We reviewed minutes of meetings between January 2018 and March 2018. The current risks of the service were discussed and this included the mandatory training compliance rates.

**Management of risk, issues and performance**

There was a Women’s and Children’s Group Risk Management Strategy (version 5.3, expiry date
February 2019). It was reviewed and approved by the Children’s Services Governance, Obstetrics & Gynaecology Governance, and the trust Governance & Assurance Committees in September 2015 and April 2016. The strategy outlined the processes for managing and escalating risks, individual responsibilities and their strategy for achieving this objective.

Key policy areas included the identification, assessment, control and review of risk, the risk register, process for escalation and assurance, reporting and management of incidents, serious incidents, never events, maternal deaths, and learning of lessons.

We reviewed the risk register. There were 13 risks associated with obstetrics and community midwifery on the directorate register, dated February 2018. There was evidence the register was reviewed and updated. We also saw the risk register was discussed in the monthly governance meeting minutes. The information included the action taken to mitigate the risks and timescales.

Staffing at Scunthorpe General Hospital (ward 26 and the central delivery suite) was added to the maternity risk register in December 2016 as presenting a high risk; and downgraded to moderate in November 2017. A further update to the risk register on 26 January 2018 stated, “…escalation has improved, however, poor for community; to be added to the risk register as a separate risk”. A separate entry for community midwifery staffing had not been added to the risk register at the time it was reviewed (early February 2018).

We found an overview of serious incidents, incidents and complaints presented in monthly Obstetrics and Gynaecology Clinical Governance meeting minutes for January, February and March 2018. Items included a summary of serious incidents that had occurred in the preceding month, incidents by hospital site for the preceding month, incidents by severity, and thematic summary of the most commonly occurring incidents. Incident data was inclusive of Obstetrics and Gynaecology services. Meeting minutes from both January and March 2018 detailed concise root cause analyses from previous (completed) investigations had been fed back to the group.

There was a Women and Children’s governance dashboard for obstetrics, maternity and gynaecology. The dashboard for April 2018 showed the number of serious incidents (by date), a summary of new serious incidents, and hospital specific incident, formal complaint, PALS, and claims data.

The ‘Maternity services Patient safety strategy 2018-2020’ (version 4) presented a plan to maximize safety and reduce harm experienced by people receiving care in maternity services. This included ensuring staff were aware of their responsibilities in relation to safeguarding patients, and take appropriate action to maintain the safety of vulnerable service users. The strategy identified areas within maternity services that required improvement. These included safe pathways and practices of care, patient feedback, safe levels of staffing, competent and skilled staff, and patient centred care. The strategy contained an action section that detailed named leads and responsibilities to achieve the outcomes. At the time received, eight of the actions had an agreed timescale for implementation recorded. These predominantly concerned actions centred around ensuring a fair patient focussed culture, good team working and good morale, and the safe use of equipment (including IT services).

The maternity dashboard was location specific (to Diana Princess of Wales, and Scunthorpe and Goole hospitals) and discussed at the monthly governance meetings. The service submitted data to the Yorkshire and Humber regional maternity dashboard. This meant the service could compare its performance against other local trusts and the Yorkshire and Humber average.
Information management

Staff reported Information technology had improved. Since our last inspection, the service had implemented the electronic Modified Early Warning Score (MEWS) and WebV.

There was a centrally held document control register. The register listed all trust policies and clinical guidelines alongside version control, review date, and stage of review (where applicable) information. A named individual at the trust had oversight of the register. The governance midwife informed us that a maternity specific document register was emailed to her each month for oversight. Appropriate actions were in place for maternity specific documents that had expired or were approaching their review date.

The minutes of the Obstetrics and Gynaecology Governance Group showed monitoring of controlled documents within the service. This included clinical documents, guidelines and patient leaflets.

Engagement

Staff informed us they felt engaged with leadership team in particular the IHOM. She was visible and approachable and provided regular updates for staff.

We noted low Friends and Family Test (FFT) responses across maternity services at the trust. NHS England published no data for the maternity friends and family test in November 2017 due to data quality concerns. The trust had less than six responses in December 2017 and January 2018 for antenatal care; this resulted in 0% recommended. The trust also reported less than six responses in four months (February, March, April 2017 and January 2018) for postnatal community performance; this too resulted in 0% recommended.

However, an external provider undertook a survey of women who had recently used maternity services at the trust in September 2017. An action plan had been developed to address women’s concerns and recommendations. For each action, there was an action lead, timescale for completion (all set for August 2018) and expected evidence of completion (anticipated changes to practice and delivery).

There was also a Maternity Voices Partnership in place at the trust. The partnership had a remit to enable hospital trust and other service providers to listen to and take account of the views and experiences of maternity service users. Parents who had had a child at the trust in the last three years were invited to join and share their experiences of care. The group was comprised of local parents, commissioners, hospital, community and council staff, and chaired by a local mother. The group met every two months in Grimsby or Scunthorpe and there was a social media page and online forum. Experiences of care could also be submitted by email.

Learning, continuous improvement and innovation

A review of maternity services was undertaken by representatives from the trust, local Clinical Care Commissioning Groups (CCG), and Healthwatch on 28 September 2017.

The trust had invited the Royal College of Gynaecologists (RCOG) to review and assess maternity services; this took place shortly after our visit in May 2018. Terms of reference showed 10 keys points for consideration, and included review and assessment of areas around: meeting national standards and indicators, current model of service delivery, patient safety culture, serious incident investigation processes and learning, staffing levels, culture,
leadership and governance, and patient engagement.

In early 2018, women who had given birth at Scunthorpe, Grimsby or Goole hospitals were asked to give a special thank you to their midwife by nominating them for an award. Staff in maternity services across the trust hosted a tea party in celebration of the midwives. The staff shared their experiences and the reasons they loved working in the profession. This took place in May 2018. On the day, the winners of the ‘NLaG Outstanding Midwife 2018 award’ were also announced.

In April 2018, the trust implemented a new National Bereavement Care Pathway (NBCP) for pregnancy and baby loss, developed in conjunction with Sands (the stillbirth and neonatal death charity).
Outpatients

Facts and data about this service

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

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

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

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

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

Total number of appointments compared to England

The trust had 385,505 first and follow up outpatient appointments from November 2016 to October 2017. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from November 2016 to October 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital (DPOW)</td>
<td>216,993</td>
</tr>
<tr>
<td>Scunthorpe General Hospital (SGH)</td>
<td>169,060</td>
</tr>
<tr>
<td>Goole &amp; District Hospital (Acute)</td>
<td>34,481</td>
</tr>
<tr>
<td>This Trust</td>
<td>420,534</td>
</tr>
<tr>
<td>England</td>
<td>103,843,026</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from November 2016 to October 2017. The percentage of these appointments by type can be found in the chart below:

The number of appointments at Northern Lincolnshire and Goole NHS Foundation Trust from November 2016 to October 2017 are shown by site and type of appointment.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

There is only one medical/dental staff member allocated to outpatients in the data received from the trust. This member of staff has completed seven out of 10 modules, all with a 100%
completion rate. Three modules were not completed.

A breakdown of compliance for mandatory courses for nursing staff in outpatients from February 2017 to January 2018 shown below:

**Goole District Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control - 1 Year</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>5</td>
<td>8</td>
<td>63%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>5</td>
<td>8</td>
<td>63%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>7</td>
<td>12</td>
<td>58%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>4</td>
<td>8</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff at Goole District Hospital failed to meet six out of the 10 training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with told us that mental health training was provided as part of mandatory training at the trust.

Mandatory training records were managed centrally, but we saw outpatient’s managers also kept local training records and received updates on staff attendance through the trust electronic staff record system.

Staff we spoke with at Goole and District Hospital told us they had no difficulty accessing training courses. However, the distance from the two larger hospitals made making sufficient time to attend training difficult. Some training had been cancelled due to winter pressures. Staff we spoke with had recently received training on site when the facilitator had visited the hospital and staff completed several modules in one day. This information was held by the department manager but had not yet been reflected in the electronic staff records.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

There is only one medical/dental staff member allocated to outpatients in the data received from the trust. This member of staff has achieved 100% completion for all three safeguarding modules.

A breakdown of compliance for safeguarding courses for nursing staff in outpatients from February 2017 to January 2018 is shown below:
Goole District Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>5</td>
<td>8</td>
<td>63%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff at Goole District Hospital failed to meet two out of the three training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We saw local staff training records held by the outpatient’s manager that showed training figures for all safeguarding training now met trust targets. This had been met when the facilitator delivered training on site instead of several staff travelling to DPOW.

Staff we spoke with were able to describe their responsibilities regarding safeguarding concerns. Staff were clear how to escalate issues and felt they were well supported if they needed to discuss any concerns.

The trust employed a safeguarding lead and supervisors across the department provided safeguarding information and support to staff.

We saw that staff had access to safeguarding policies on the trust intranet. This also included guidance for staff regarding abuse such as female genital mutilation (FGM). FGM is defined by the World Health Organisation as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’.

Children attended some clinics, within outpatients, for example in ophthalmology.

The service met the requirements of the Intercollegiate Document, third edition (March 2014) that made recommendations regarding the level of training and responsibility of healthcare staff.

**Cleanliness, infection control and hygiene**

All areas we visited were visibly clean and tidy.

We saw cleaning schedules were in place to ensure rooms were clean prior to the clinic start times. Domestic staff we spoke with told us they used cleaning schedules and checklists to follow. We saw checklists were signed and up to date. All the rooms in outpatients had been cleaned on the evening before the inspection.

In the areas we visited, all seating in the waiting areas and couches in the consulting rooms were in good condition without rips and tears and were wipe clean. The areas were free from clutter and there was sufficient space for patients and staff to move freely. There were some designated waiting areas for patients with children and we saw these areas were clean and toys were clean. Staff we spoke with told us they were responsible for cleaning toys; however, we did not see cleaning records for this.
We saw that staff adhered to bare below the elbow protocols.

We saw clinic staff participated in hand hygiene audits and compliance was 100% for every month.

**Environment and equipment**

Staff in the ophthalmology clinic could request equipment for bariatric patients from another ward at the hospital if they required it. The resuscitation trolley was checked daily in ophthalmology.

Resuscitation equipment was available on trolleys at various locations in the main outpatient areas and near other clinics. Daily checks were completed and tamper proof numbered tags were used to show if the contents had been accessed. Full internal checks of the trolleys were completed weekly. We examined the checklists of trolleys and saw that appropriate stock was in place and was regularly updated. Defibrillator checklists were completed weekly for the full calendar year to date.

Utility rooms were visibly tidy and equipment was stored appropriately. Sharps bins were checked throughout the outpatient areas and all were appropriately labelled, signed and the contents were all below the fill lines. We saw that waste bins were available to enable waste to be segregated appropriately.

All staff we spoke with told us they had sufficient personal protection equipment (PPE) such as gloves and aprons.

Equipment we observed was visibly clean and staff used ‘I am clean’ stickers to show when items had been cleaned.

We checked a range of items including, syringes and dressings. We found all items were within expiry date and staff confirmed that processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

Medical equipment was serviced on site. Staff we spoke with told us that technicians usually responded quickly to requests for checks and repairs. We checked equipment including a bladder scanner, blood pressure machine and cuffs, and we saw that this was clean, within service date and safety tested.

**Assessing and responding to patient risk**

At our last inspection in 2016, the outpatient management team told us they had developed a clinical validation policy that had been agreed by all specialities to manage the risks posed by lengthy waiting lists.

The management team told us clinical staff were validating waiting lists with a view to prioritising patients for clinic review and discharging patients where appropriate. Alongside this, administrative staff had reviewed waiting lists to cleanse data for example ensuring those patients not requiring follow up were removed. At this inspection we were told similar information but some staff we spoke with explained in the past the work had been completed and finished as a single project and not maintained. This meant that new waiting lists had developed and staff we spoke with at this inspection provided the inspection team with different figures and measures relating to numbers of new and follow up patients waiting for appointments. We were not assured that there was clear oversight of the waiting lists and the risk posed to patients.
Following our inspection, the trust provided information which showed that waiting Lists continued to be reviewed on a regular basis and a daily validation report was in place.

Staff we spoke with told us a clinical harm review was being carried out for all patients on waiting lists. Managers we spoke with told us clinical validation was ongoing in a number of specialties and specialty consultants were responsible for the validation and how they mitigated the risks. However, it was not clear if this had commenced in all specialties. Senior managers we spoke with told us that any patient waiting over six months would receive a clinical harm review and that this was carried out by the specialties.

The clinical harm group identified that 181 patients had died whilst waiting for a follow-up appointment. At the time of inspection staff told us there had been no formal reviews of these deaths to see whether the delay in appointments or treatment may have contributed to the patient deaths.

The Trust created a new post to manage clinical administration and patient access. A Project Director had been appointed on a fixed term basis to manage the clinical harm project. They had introduced an electronic reporting system to identify all patients requiring review and a new outpatient data collection form for all clinic staff to use to ensure all follow up information was available. Patients were asked to hand their form to the clinic reception staff following any outpatient appointment. Staff we spoke with told us they were confident this new system ensured patient details were captured and follow up arrangements were made before patients left the department. They felt this process would prevent any more patients being lost to follow up. However, staff did explain that numbers of patients waiting for appointments were increasing month by month.

At our last inspection we noted discharge and referral data showed an initial peak of activity where numbers of discharges declined then started to rise again, gradually reaching a peak in September 2016. This corroborated what staff had told us about clinical validation of waiting lists stalling for several months following the initial activity following our last inspection. This appears to have been a repeating pattern over the last three years with a lack of progress made because once numbers were reduced the project was closed. This lack of progress meant that numbers of patients waiting for follow up appointments continued to accumulate and at this inspection numbers were higher at 31,295 patients on the waiting list in March 2018.

At our last inspection managers told us that work with NHS Improvement (NHSI) had included looking at the reasons why there was a mismatch between demand and capacity, quantifying the capacity and demand in each specialty and risk rating each of the specialties. At this inspection specialty managers we spoke with told us meetings were being held with managers, consultants and administration staff to review the waiting list position and to manage and prioritise capacity and demand for appointments.

The trust had appointed a cancer project lead in October 2017 whose role was to address diagnostic delays and the trust’s decline in performance for 62 day waits for treatment for cancer patients. They told us their aim was “to change the outcome in some troubled specialties”. Staff we spoke with told us the trust used cancer service coordinators to input patient details and multidisciplinary teams (MDTs) worked together to assess individual patient needs. However, the trust cancer lead told us they estimated only 20% of clinicians and 50% of specialist nurses took part in cancer MDTs. They reported difficulties in getting clinicians to mark test requests with the correct priority therefore possibly delaying diagnoses.

Staff we spoke with reported long waiting times within specialties such as cardiology. They were seeing an increase in the number of cardiology patients waiting so long for pacing appointments they were being admitted acutely with urgent requirements.
At our last inspection, managers we spoke with told us staff were ready to start real-time validation of patient tracking lists (PTLs). This would ensure waiting lists were managed appropriately and the quality of data input would be improved and prevent issues such as no due date and pathways being left open incorrectly. At this inspection, staff we spoke with told us this work was continuing and they felt this ensured that patient outcomes (e.g. whether discharged or for further investigation, treatment or appointment) were correctly coded.

Staff we spoke with told us that if a patient became unwell during clinic they would seek immediate assistance from medical staff in the department. The patient would then be transferred by ambulance to the nearest emergency department for assessment.

In the case of a patient collapse in the outpatient department, all staff we spoke with were aware how to raise the alarm and raise a cardiac arrest call. Staff we spoke with told us if they needed help with a situation they could call switchboard for the crisis team or security. At Goole and District Hospital there had been a recent emergency when a member of the public had suffered an anaphylactic shock in the corridor outside the department. Staff we spoke with told us they had encouraged the person to self-administer their emergency adrenaline injection and made a medical emergency call.

Specialist nurses gave patients their contact details so they could escalate any change in condition or seek advice when they needed to.

Staff we spoke with told us they had introduced an adapted ‘World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery’ prior to performing invasive procedures such as biopsies and intravitreal injections with a future plan to roll it out for outpatients. We reviewed the patient notes from a dermatology minor procedures clinic but did not see that the checklists had been used.

Staff we spoke with told us there was no formal process or policy to manage patients who did not attend their appointment. However, following our inspection, the trust provided evidence of a policy and standard operating procedure for the management of patients who did not attend appointments.

Staff we spoke with did not know of any formal process to follow for patients requiring mental health support or those living with learning difficulties. We observed staff relied on carers to provide information about patient needs and when we checked patient records we found no entries relating to individual patient needs.

**Nurse staffing**

The trust has reported their staffing numbers below for the period from January 2017 to January 2018 for outpatients.

<table>
<thead>
<tr>
<th>Site</th>
<th>January 2018</th>
<th>January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planned staff – WTE</td>
<td>Actual staff – WTE in month</td>
</tr>
<tr>
<td>Goole and District Hospital</td>
<td>2.6</td>
<td>2.6</td>
</tr>
</tbody>
</table>
In January 2018 the trust had a nursing and midwifery staff fill rates of over 100% outpatients, this was more WTE staff in post than the trust planned to provide safe and effective care. For the previous year (January 2017) Goole and District Hospital had the required WTE of staff in place with a 100% fill rate.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Outpatient managers managed nurse and health care assistant staffing levels depending on what clinics were running each day. Staffing was planned with individual specialties and was flexible to meet the clinic needs.

**Vacancy rates**

From February 2017 to January 2018, the trust reported a vacancy rate of 2.3% for nursing & midwifery staff in outpatients:

- Goole District Hospital: 6.7% - above target of 6.3%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

All senior staff we spoke with were aware of their vacancies at each clinic. Staff we spoke with told us that shifts were covered internally and no agency staff were used.

**Turnover rates**

From February 2017 to January 2018, the trust reported a turnover rate of 23% for nursing & midwifery staff in outpatients;

- Goole District Hospital: 15%

All three sites did not meet the trusts turnover target of 9.4%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From January 2017 to December 2017, the trust reported a sickness rate of 5.8% for nursing & midwifery staff in outpatients;

- Goole District Hospital: 2.4% - below trust target of 4.1%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and agency staff usage**

From February 2017 to January 2018 the trust did not employ any bank or agency staff within outpatients.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical staffing**

Medical staffing levels were managed by the individual specialities across the trust. Some specialties reported several consultant vacancies with posts proving very difficult to fill and we
saw this had a direct effect on the trust’s ability to manage new and follow up appointments.

Records

All patient records were paper based. However, patient letters including referral letters and all diagnostic results were easily accessible via electronic systems. Staff we spoke with told us that if records were not located before a clinic then the administration team would make up a temporary set of records, which would be merged, with the original set when located. However, staff we spoke with told us this rarely happened.

The trust did not collect data regarding the percentage of patients seen without a full medical record. However, staff we spoke with told us there was an escalation process in place for them to use when notes were unavailable for clinics.

We looked at the medical records of four patients attending outpatient clinics. We found these were of a generally good standard, legible and in line with professional standards although only brief information was recorded.

Record entries were mostly signed and dated but staff designations and times were missing. They contained up to date information about patients including referral letters, copies of letters to GPs and patients, medical and nursing notes.

We found records were stored securely and following the daily clinics, we saw records were locked away in the medical records department.

Medicines

Medicines we checked at Goole and District Hospital in the ophthalmology department were in date and we were told the cupboards were checked weekly by pharmacy. Refrigerator temperature checks were checked during clinic opening times.

Medicines were stored in locked cupboards and refrigerators. We checked a range of medicines and found them to be in date and stored appropriately in locked cupboards.

No controlled drugs (CDs) were stored in the areas we inspected.

Staff monitored and recorded the temperature of the rooms where drugs were kept. We reviewed the temperature records in clinic rooms and saw that daily checks had been completed. We saw the temperatures were within acceptable limits. Staff we spoke with could explain the process to follow should temperatures fall outside the required range.

Clinicians used a mixture of electronic prescribing and FP10 prescriptions. The FP10 prescriptions were securely stored in a locked cupboard. Prescription records were kept securely and separately from prescription books.

We saw a number of patient group directions (PGD) were used across a number of clinics, including ophthalmology and dermatology. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers
follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2017 to December 2017, the trust reported no incidents classified as never events for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from January 2017 to December 2017.

Both incidents were classified as treatment delay meeting SI criteria with two (100% of total incidents).

(Source: Strategic Executive Information System (STEIS))

The CQC received information on 19 June 2018 that the trust declared a serious incident on 18 May 2018 that was found during a validation exercise. A patient had been missed from the cancer tracking system and was treated on a routine 18 week pathway but went on to be diagnosed with cancer. The patient did not receive treatment until day 212 in their pathway.

Staff we spoke with told us that they were able to log onto the intranet and review never events and serious incidents across the trust and the learning from these incidents. Staff shared learning from incidents across the outpatient departments of three hospitals within the trust. Managers shared alerts and actions for change following incidents with staff at formal meetings and managers’ rounds at the start of each shift.

All staff we spoke with understood the incident reporting process and described how they would report an incident. Staff we spoke with told us that incidents were shared through emails and staff handovers where staff received feedback on incidents and learning was shared.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Local policy and national documents relating to duty of candour were available via the trust intranet. Staff we spoke with were aware of the need to be open and honest when something went wrong.

Safety thermometer

The safety thermometer was not used in outpatients. However, outpatients did record and display hand hygiene audit results. Senior staff completed a monthly 'A3' outpatient dashboard that showed performance data which was shared with staff and trust management.

Is the service effective?

Evidence-based care and treatment

Staff had access to a trust intranet which contained the trust policies and procedures available to
staff. Staff we spoke with told us they worked within standards and guidance applicable to their practice.

Audit was generally carried out within the specialities that provided outpatients. Staff we spoke with told us they were notified of audit requirements from the trust’s governance team. Staff in ophthalmology told us they participated in national audits, for example the national cataract audits. Podiatry took part in national audits such as a diabetic foot audit annually and we were told the results were above the average nationally. The podiatry team were part of a clinical network for diabetic foot conditions.

Respiratory outpatient’s staff we spoke with told us they participated in national audits such as the asthma audit and chronic obstructive pulmonary disorder audit. Staff in the ear, nose and throat clinic told us they completed scope audits to check cleanliness.

The trust had audit days for departments; however recently there had been cancellations of these to address the clinical harm reviews.

We were told during our inspection that national audits were generally managed at trust level and staff would be informed when audits were required to be completed. Senior managers told us that outpatients was part of the clinical support services audit programme.

The podiatry team had a set referral pathway for the service and diabetic foot pathways for example.

**Nutrition and hydration**

Staff we spoke with in outpatients told us they were able to provide drinks to patients who had waited a long time or who required a drink. They were also able to provide food to patients if required in the outpatient clinics. Some areas we visited had water dispensers available.

**Pain relief**

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

**Patient outcomes**

Audits were carried out in outpatients but these were managed by the individual specialities providing the clinics. Outpatients as a service did not generally monitor patient outcomes. Patient outcome data was managed by the individual specialities.

**Follow-up to new rate**

From November 2016 to October 2017,

- The follow-up to new rate for Goole & District Hospital (Acute) was similar to the England average.

**Follow-up to new rate, Northern Lincolnshire and Goole NHS Foundation Trust.**
Competent staff

Staff we spoke with told us they received training in addition to their mandatory training. Staff we spoke with told us they had received annual appraisals. Some staff in ophthalmology had completed dementia training to provide further understanding of dementia, training on eye drops and visual field test competencies.

We were told that phlebotomy staff completed internal training and had reviews of competency every two years. There were two stages of training which included theory and practical training. Pathology offered training to different staff in the department.

Some staff we spoke with told us they received clinical supervision and other staff had been supported to complete prescribing courses and additional studies.

Around 400 staff in the service had completed training in referral to treatment indicators and the access policy to increase their knowledge of these.

Senior managers we spoke with told us there was line manager training available.

There were link nurses in ophthalmology at Goole and district hospital for infection control and a learning disability link nurse.

Some staff attended external regional meetings applicable to their practice.

Appraisal rates

From April 2017 to March 2017, 100% of nursing staff within outpatients at the trust had received an appraisal, this met the trust target of 95%.

A breakdown by site is shown below;

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff who received an appraisal</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales</td>
<td>13</td>
<td>13</td>
<td>100.00%</td>
<td>95.00%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Multidisciplinary working

Ophthalmology had multidisciplinary team meetings which were held at Scunthorpe Hospital and oncology had multidisciplinary team meetings at each site. The podiatry team had multidisciplinary team meetings which included staff from the diabetes speciality.

Clinical nurse specialists were able to refer patients to occupational therapists and physiotherapists if required.

Clinical nurse specialists were available in a number of clinics visited to provide further support and advice to patients. There was multidisciplinary team working in outpatients with medical staff and nursing staff working together along with clinical nurse specialists in departments such as cardiology.

Seven-day services

Seven day services were generally not provided by outpatients.

Managers told us the pathology laboratory was open 24 hours a day with on-call staff available.

Health promotion

Outpatients had held smoking cessation groups. There were patient information leaflets available in different outpatient specialties.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with in ophthalmology told us they had recently received mental capacity act training.

The oncology pre-assessment clinics had consent paper work for use in clinics. Staff we spoke with were able to talk about taking consent. Podiatry and therapies used electronic record systems and this allowed consent to be recorded on the system.

Dermatology notes at Goole and District Hospital contained signed consent for minor operations and followed National Institute of Care and Excellence guidance for consent.

The trust provided details on mental capacity act training compliance for outpatients. This showed 88.8% of staff had completed the training against a trust target of 95%.

Is the service caring?
**Compassionate care**

During our inspection we heard staff introducing themselves to patients in clinics.

We observed medical and nursing staff interacting with patients. Staff introduced themselves, were friendly and welcoming and were quick to offer help when required. The outpatient survey showed that 95% of respondents stated that staff members introduced themselves when they came into direct contact with them. The outpatient survey did not detail the date of the survey.

Administrative staff and nurses greeted patients on arrival to main outpatients. Staff were friendly and helpful and we observed staff offer assistance and directions.

We spoke with one patient; whose feedback was positive and they described staff as being reassuring and caring. They told us they felt supported and treated with dignity and respect.

Patient comments stated, “staff were very kind”, “warm and lively and an asset to the team”.

Patient feedback was gathered in different ways: experience data for the previous quarter was displayed, and a patient satisfaction board showed patient indicators of good, satisfactory and unsatisfactory. These were colour coded for each clinic so staff could see how patients had responded regarding each area. Most indicators showed a good experience with just a few showing as satisfactory. Patients who felt they had had an unsatisfactory experience were encouraged to speak with a member of staff. There were no unsatisfactory markers. There was also a patient comments book. Most of the written comments were very positive.

The trust provided an outpatient department patient questionnaire for Goole and District hospital; however, this did not have a date attached. One hundred percent of respondents felt they were treated with dignity and respect. Seventy three percent of respondents felt relaxed regarding their experience of their department, Fourteen percent stated they felt nervous, nine percent stated staff did their best to put them at ease and four percent had a reasonable experience.

The trust provided an outpatient department patient questionnaire for Goole and District hospital; however, this did not have a date attached. Sixty four percent of respondents stated their overall experience of the department today was excellent and 36% stated their experience was good.

**Emotional support**

We saw staff names and photographs were on display in the reception area, this meant patients could see which staff worked in the department.

Clinical nurse specialists provided additional support and in depth knowledge to patients with a range of conditions and disease specific information. Staff we spoke with told us about specific support they provided such as a cancer support and social group. Staff provided a wide range of leaflets to support patients at appointments and to enable self-care at home.

We saw patient information leaflets were available about emotional wellbeing.

The department worked closely with the MacMillan Cancer Care team who provided a wide range of information and leaflets for patients and their families.

We saw information about the availability of chaperones in the main outpatient waiting room. Staff we spoke with told us that they were able to provide a chaperone when it was required.

**Understanding and involvement of patients and those close to them**
We observed staff interacting with patients and relatives in clinics and imparting information in a way that was appropriate for the patient’s understanding. One patient told us “they gave me information on what to do if anything changes”.

We saw a patient comments book where one person had written staff were “very helpful and explained things that no other person did”.

Patients received a copy of the letter sent to their GP following consultations. This ensured that patients were kept up to date with all decisions made about their care.

Staff directed patients to a range of appropriate support agencies and self-help groups.

We saw posters were displayed on sepsis in children, bug of the month, cancer awareness month, and patient information leaflets and staff explained these were available in different languages via the trust intranet.

Health trainers ran smoking cessation sessions and weight loss activities for orthopaedic patients who were required to reduce their BMI (body mass index) before undergoing hip or knee replacement surgery.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Volunteers were available at main reception to assist people with directions at the hospital. Patients could check in at a reception desk or use the electronic check in desks at the entrance to outpatients. There were seating areas in the different outpatient areas at the hospital; however, there were no bariatric chairs available for use in waiting areas in outpatients.

Ophthalmology outpatient clinics times were Monday to Friday 8:30am to 5:30pm. Outpatient clinics generally were open between 8am and 4:30pm Monday to Friday. The phlebotomy service was available in outpatients between 8am and 5pm Monday to Friday.

Phlebotomy outpatients had seating available for patients and a reception desk for patients to book in. Podiatry outpatients had water available for patient use, patient information leaflets, for example on diabetes, magazines in the waiting room and seating for patients waiting for clinics.

Outpatient clinics could offer patients a bleep if the waiting times in clinic were long and staff would call the bleep when their appointment was ready.

Senior managers we spoke with told us they met regularly with the clinical commissioning groups regarding service delivery and attended regular business meetings for outpatients. Capacity and demand was managed by individual specialities.

There were limited clinics which had put on extra evening and weekend clinics to address backlogs and provide additional appointments, however there had been no recent evening or weekend clinics at Goole and District Hospital.

Virtual clinics were provided in ophthalmology by the medical illustrator service who completed a visual acuity test, scan and optical coherence tomography (OCT) which is an imaging technique and these were then reviewed by a consultant a few days later. There were four virtual clinics each week. Staff we spoke with told us there was a new virtual clinic being initiated for diabetic patients. These virtual clinics did require the patient to attend clinic.
Meeting people’s individual needs

Bariatric equipment was not routinely available in ophthalmology outpatients; however, staff could request bariatric equipment from another ward if required.

Outpatient clinics we visited had a range of leaflets available for patients. Some areas provided these leaflets in different languages.

Some areas had dementia friendly environments, for example clocks and toilet signage. Staff we spoke with in outpatients told us that they would try to get dementia patients into clinic as promptly as possible and would ensure a quiet area was available for use if required. There was a dementia team in the trust that staff could call for advice.

Staff in ophthalmology told us there was no designated quiet room for patients but could find a quiet space for patients if required. Staff we spoke with told us they would prioritise vulnerable patients attending clinic where required.

There was no direct access to mental health advice for staff in outpatient departments. Staff would refer patients to the emergency department if required.

The outpatient patient survey showed that 100% of respondents found the environment in the waiting room pleasant and comfortable.

Interpreter services were available to departments and could be requested when needed.

Access and flow

The previous inspection found concerns with waiting lists and referral to treatment indicators. During this inspection we found there were still issues and concerns around waiting lists for appointments and most specialities were not achieving their referral to targets indicators.

The planned care key performance indicator dashboard showed there were 31,295 follow up outpatients overdue as at March 2018. Senior managers we spoke with told us that around 14,518 of these were part of the clinical harm review and 6,000 were patients who did not have a review date assigned. The previous inspection found that not all patients had a due date on the patient administration system. During this inspection, senior managers told us there were still patients without a due date on the patient administration system; however, managers told us they knew who these were as they were working through the 6,000 patient backlog for due dates. We were told 2,000 of these patients could not have a due date for follow up appointments as they were waiting for an inpatient episode.

The planned care key performance indicator dashboard April 2017 to April 2018 showed there were 320 patients waiting over 52 weeks for an appointment at the trust as at March 2018.

The previous inspection found that the trust aimed to achieve their referral to treatment required position by March 2018. During this inspection, this had not been achieved and senior managers told us there was an action plan for medicine and surgery but the trajectory for improvement and for achieving the referral to treatment indicators and follow up appointments would not be decided until the end of quarter one (June) 2018. Senior managers told us there had been some recent improvement in cardiology where the backlog was 3,600 waiting for follow up appointments and the service had reduced this to 3,300 in the previous six weeks.

The services had worked with the intensive support team to create a capacity and demand model
and the focus initially was on the eight most challenged specialties. The capacity and demand plans were being completed by individual specialities at the trust.

The trust provided an improving together programme document for the outpatients and patient access work stream highlight report which showed information such as key activities last month and next month, key performance indicators and top risks and issues.

The trust provided a project document for outpatients. This detailed the project scope and work stream risk log. The trust also provided a project brief for outpatient efficiencies and patient access which was dated October 2017 and included a project plan.

The previous inspection found issues with the trust’s recording of some referral to treatment indicators in outpatients. Senior managers we spoke with told us that they had started to audit recording of some indicators and waiting lists at the trust; however, this had only happened in five specialities at the time of the inspection.

Individual clinics and specialities booked appointments for patients and patients would contact these clinics directly if required. Staff we spoke with were aware there were long waiting times for clinic appointments.

We saw in outpatient clinics we visited that staff would highlight the waiting times to be seen in clinics on display boards in the waiting areas. Staff would also inform patients verbally if the wait in clinic was longer than expected.

The April 2017 to April 2018 outpatient key performance indicator dashboard showed a target of 95% for outpatient’s clinic slot utilisation rate and this was 86.5% for Goole and District Hospital. This was worse than the trust target.

The April 2017 to April 2018 outpatient key performance indicator dashboard showed a target did not attend rate of 5% and the dashboard showed that the twelve months total for Goole and District hospital was 7.2%. This was worse than the trust target.

The April 2017 to April 2018 outpatient key performance indicator dashboard showed a target of 7.5% for hospital cancellations under six weeks and the dashboard showed that the twelve months total for Goole and District Hospital was 6.2%. This was better than the trust target.

The trust had a key performance indicator for appointment slot issues and the outpatient dashboard April 2017 to April 2018 showed a target of 4% and the dashboard showed that the twelve months total for Goole and District hospital was 34.9%. This was worse than the trust target.

The April 2017 to April 2018 outpatient key performance indicator dashboard showed the inpatients booked slot utilisation rate was below the trust target of 95%. In April 2018 at Goole and District Hospital it was 86.7%.

An outpatient patient survey at Goole and District Hospital showed that 73% of patients waited 0 – 15 minutes longer than their appointment time, 13% of patients waited 15 – 30 minutes longer and 14% of patients waited 30 – 45 minutes longer. No date was attached to the survey.

The same outpatient survey showed that 58% of respondents were given an explanation of the appointment delay by staff.

### Did not attend rate

From November 2016 to October 2017,

- The ‘did not attend’ rate for Goole & District Hospital (Acute) was higher than the England
All three sites were generally higher than the England average from November 2016 to October 2017.

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Northern Lincolnshire and Goole NHS Foundation Trust.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for November 2017 showed 75.3% of this group of patients were treated within 18 weeks versus the England average of 88.8%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Northern Lincolnshire and Goole NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

One speciality was above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>98.8%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>97.4%</td>
<td>93.8%</td>
</tr>
</tbody>
</table>

Fourteen specialties were below the England average for non-admitted RTT (percentage within
18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>86.5%</td>
<td>88.1%</td>
</tr>
<tr>
<td>Other</td>
<td>86.1%</td>
<td>91.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>83.8%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>83.0%</td>
<td>87.2%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>82.2%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.5%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>76.3%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>72.1%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>72.0%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>71.0%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>70.3%</td>
<td>90.2%</td>
</tr>
<tr>
<td>ENT</td>
<td>69.3%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>63.7%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Neurology</td>
<td>24.5%</td>
<td>82.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance.

In the latest month, November 2017 73% of this group of patients were treated within 18 weeks compared to the England average of 89%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Northern Lincolnshire and Goole NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

One specialty was above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>96.6%</td>
<td>90.6%</td>
</tr>
</tbody>
</table>

No specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

(Source: NHS England)
Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Northern Lincolnshire and Goole NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Northern Lincolnshire and Goole NHS Foundation Trust

The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Northern Lincolnshire and Goole NHS Foundation Trust
During our inspection senior staff we spoke with told us there was no current target date for improvement of the 62 day wait and an action plan was being developed to address the issues.

Learning from complaints and concerns

Summary of complaints

Goole District Hospital

From February 2017 to February 2018 there were eight complaints about outpatient services at Goole District Hospital (1.6% of total complaints received by the trust and 5% of complaints about outpatient services overall).

The trust complaints data shows these mapped to eight different specialities with no themes identified.

Overall complaints about outpatient services at Goole District Hospital took an average of 38 working days to investigate and close complaints. This was not in line with the trust targets for closing complaints within 30 working days, but was within the further target of 45 working days.

The most common subjects complained about in outpatients services at Goole were patient care with five complaints and appointments with two complaints.

There was no evidence of complaints which related to access to treatment for outpatient services at Goole District Hospital.

Staff we spoke with told us complaints were often regarding waiting times in clinics and told us they had changed the boards in waiting areas to include the doctor’s clinic and the waiting times.

Staff we spoke with in ophthalmology told us that following a complaint regarding waiting times in clinic, the service had reintroduced specific waiting times in ophthalmology surgical clinics so patients arrived for clinics at different times. Staff we spoke with told us they would generally get to know about complaints.

Is the service well-led?

Leadership

Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available for support when required. However, staff we spoke with told us senior leaders were less visible in departments. Staff views varied on the trust leadership team being visible in departments.
Some staff we spoke with told us they had met the trusts recently appointed senior leadership.

Outpatients were part of the clinical support services directorate.

There was a structure for the management of outpatients. Overall leadership was provided by the clinical support services senior management team. There was a matron for outpatients covering all sites. Scunthorpe Hospital and Goole and District Hospital were managed by one manager across both sites. Outpatients had registered nursing staff working across clinics and healthcare assistants worked in outpatients across the different outpatient clinics.

The clinical services directorate management group had been formed in June 2017.

Since the previous inspection, the trust had appointed a senior manager to address concerns with patient administration. Senior managers we spoke with told us work was progressing with clinical validation and training on logging the correct follow up with patient administrators and that the focus was on stabilisation and understanding of where the trust was with waiting lists. The aim was to reduce waiting lists and ensure visibility of waiting lists in a sustainable way.

Senior managers we spoke with were aware there were challenges with waiting lists for outpatient appointments and issues with referral to treatment indicators.

**Vision and strategy**

There was no documented strategy or vision for outpatients across the trust. Most staff we spoke with were not aware of the trusts vision and values. We saw the vision of the trust on display in some areas we visited, for example in main outpatients.

Senior managers we spoke with told us they were working with commissioners to address issues around capacity and demand. The trust had received previous reviews from external organisations of waiting list issues.

Senior managers told us their focus for the next twelve months was around waiting lists, managing capacity and demand, clinical harm reviews and patients waiting over 52 weeks.

The priority was to work with the patient administrative lead in outpatients to provide outpatient services. Capacity and demand was being managed by individual specialities.

**Culture**

The previous inspection found concerns around the culture of outpatients. During this inspection, most staff in departments told us there was good teamwork amongst department teams, openness and honesty in teams and overall staff were positive about working in their departments. Most staff we spoke with told us they felt supported.

Staff we spoke with told us morale was generally good; however, it could vary at different times and had been low in some services previously.

Staff we spoke with told us about a lack of communication from the senior leadership team in outpatients.

**Governance**

Senior managers for outpatients described the governance arrangements. We were told that outpatients had a monthly governance meeting and that senior managers attended the clinical
support services governance meeting. There was director level staff at this meeting where concerns and issues could be escalated to the board at the trust. The clinical support services group had a monthly meeting.

Outpatient managers attended the governance meetings.

Minutes from the December 2017 and April 2018 governance meeting showed that National Institute of Health and Care Excellence, national patient safety alerts, infection, prevention and control and the risk register were part of the agenda. Complaints, incidents and mandatory training were also part of the agenda for governance meetings in the clinical support services directorate.

Due to the issues around waiting lists and backlogs of patients for outpatients, the trust had started a clinical harm review group where they were reviewing around 14,000 patients for clinical harm. The previous inspection highlighted a number of issues and concerns around patients where no due date had been attached to the patient administration system, patients waiting over their due date and referral to treatment indicators not being met. At this inspection we found the management of these concerns had been slow to begin.

Since the last inspection, the trust had appointed a senior manager for patient administration and there was further documented information on the actual number of patients in the follow up appointment backlog and clinical harm review. We were told there were a number of different actions taking place to address the concerns and issues around waiting lists. Clinical and administrative validation of waiting lists was ongoing; however, this was not complete across all specialities at the time of this inspection.

Waiting lists were managed by the specialities they were part of, for example, medicine and surgery managed their own waiting lists.

A staff member from the phlebotomy service attended a regular clinical governance trust meeting.

There was a quality and safety meeting every two months for clinical support services.

**Management of risk, issues and performance**

Managers had access to performance information such as staffing levels and sickness levels. Each outpatient department had a monthly performance report which detailed performance information that was used during meetings.

The trust had failed to address concerns about waiting lists and complete clinical validation of patients in the waiting list backlog from the previous inspection in 2016. The previous inspection found that the trust was finding cohorts of patients which were not being effectively managed. We were told during this inspection that the 31,295 patients was the total number of patients in a backlog for outpatient appointments at the trust.

Outpatients had a risk register and we were told this was reviewed monthly and this was on the agenda for governance meetings. Senior managers we spoke with told us the trust had provided risk register training. The trust had an incident reporting system which staff could report incidents regarding outpatients.

Pathology services had key performance indicators which managers told us they monitored monthly. Managers told us there was a turnaround time of one hour for urgent emergency department requests and we were told normally 90% of these were done on time. The target time for general practitioner requests to pathology was 24 hours if specialist analysis was required.
The trust provided us with an outpatient care key performance indicator dashboard from April 2017 to April 2018. This included various performance information such as did not attend rates and hospital cancellations.

Senior managers told us there were daily patient tracking list huddles in five specialties with team leaders, service managers and administrative staff and that each division had a weekly performance meeting.

**Information management**

Staff had access to electronic systems across outpatients, for example access to policies and procedures through the trust intranet and electronic incident reporting system.

Managers had access to performance information such as key performance indicator dashboards.

Senior managers told us there had been no recent information governance issues in outpatients.

**Engagement**

Senior managers we spoke with told us there was a clinical support services newsletter for staff.

We were told the trust had an open access physiotherapy service for staff and access to staff counselling.

Friends and family test surveys were carried out in outpatient’s; however, we did not see any results from these. Senior managers told us they also completed a quarterly patient satisfaction survey.

The trust provided information highlighting they did not complete staff surveys. Senior managers told us that the new senior leadership were meeting to work on priorities such as morale and had a listening into action campaign. There was a staff magazine and newsletter at the trust.

There had been four staff engagement workshops for the clinical administrative teams and nursing staff to address staff dissatisfaction challenges.

Outpatient team meetings did occur in a number of clinics.

Staff in phlebotomy services had a weekly staff meeting. Ear, nose and throat outpatients had a staff meeting every two weeks. Ophthalmology team meetings at Goole and District Hospital were less frequent and staff we spoke with told us they use a communications book within the department.

**Learning, continuous improvement and innovation**

The podiatry team had won the star award 2017 at the trust. The ophthalmology team had also won the star award from the trust.

The pathology service were in the process of implementing a new monitoring system with a dashboard to more easily identify any issues. This dashboard would display sickness levels, complaints and compliments for example.

In ophthalmology, there had been virtual clinics for the last nine months where patients attended to see the specialist nurses.
**Diagnostics**

**Facts and data about this service**

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

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

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

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

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

**Is the service safe?**

**Mandatory Training**

The department made sure that all diagnostics and radiology staff had undergone specific training in handling radioactive and hazardous substances in line with their roles and responsibilities. The department had produced a workbook about the dangers of working in the radiology department for all staff including domestic and portering staff to complete to ensure patient and their own safety.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training.

Medical staff worked cross site and the information for medical and dental staff is for all medical staff working in the diagnostics departments at Goole, Scunthorpe and Diana Princess of Wales (DPOW).

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control - 1 Year</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflicts Resolution</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Allied health professionals (radiographers) at Goole Hospitals were included in the training figures for Scunthorpe Hospitals because they had the same manager as Scunthorpe Hospital.

Mandatory training for allied health professionals

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level two</td>
<td>102</td>
<td>111</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level one</td>
<td>101</td>
<td>111</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act</td>
<td>95</td>
<td>111</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>103</td>
<td>111</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>101</td>
<td>111</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Harassment and Bullying awareness</td>
<td>101</td>
<td>111</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>104</td>
<td>111</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>94</td>
<td>111</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls</td>
<td>99</td>
<td>111</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent</td>
<td>89</td>
<td>111</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>106</td>
<td>111</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Non patient Handling</td>
<td>106</td>
<td>111</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>107</td>
<td>111</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness</td>
<td>99</td>
<td>111</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Challenging behaviour</td>
<td>107</td>
<td>111</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

We spoke with staff working at Goole hospital about mandatory training. They told us that they were able to access training and that their manager would remind them when they needed to update.

Safeguarding

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for medical and dental staff across the trust is below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall mandatory training completion rate for medical and dental staff in diagnostics was
100% within the department with all modules except safeguarding adults level 1 meeting target.

A breakdown of compliance for safeguarding courses from February 2017 to January 2018 for allied health professional staff (radiographers) Scunthorpe General Hospital is below. The training information about staff working at Goole hospital was included in the training data for Scunthorpe General Hospital because they shared the same manager as Scunthorpe General Hospital.

Goole Hospital and Scunthorpe General Hospital combined

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level one</td>
<td>104</td>
<td>111</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level two</td>
<td>102</td>
<td>111</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level one</td>
<td>101</td>
<td>111</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust did not provide us with safeguarding training information for nursing staff who worked in diagnostics and radiology therefore we were not assured that nursing staff were up to date with safeguarding training requirements.

Staff described to us how they made sure they were scanning the correct patient by using the three-point ID check. This made sure patients were not exposed to incorrect doses of radiation or unnecessary exposure. They made sure patient had the right scan first time.

Staff told us they knew about female genital mutilation and what action to take should they have any concerns about patients attending the department. There was information on the hospital intranet about how to report safeguarding concerns about patients. Staff also told us that if they were unsure what action to take, they would speak with their line manager, one of the doctors or the safeguarding team within the trust for advice.

There was information about safeguarding on the walls of the waiting room, visible where patients, visitors and staff could see it.

**Cleanliness, infection control and hygiene**

During our inspection we looked at the cleanliness of the department. All the rooms in the department were clean and uncluttered.

There were cleaning schedules in place and these showed regular cleaning of the department and the equipment being used. Staff wiped down x-ray machines between patients and used a disposable blue roll on beds. This was changed after every patient.

If a patient required isolation because of risk of infection, domestic staff carried out a thorough cleaning of the treatment room to prevent the potential spread of infection after treatment. Such patients were also seen quickly to reduce the length of time in the department.

There were some toys for children to play with. These met with infection prevention and cleanliness guidelines and were cleaned regularly.

There was sufficient personal protection equipment such as gloves and aprons available to staff. There were processes in place to manage clinical waste within the department.
Hand hygiene audits were carried out in the department to ensure staff followed the correct hand washing procedures between patients. Results were good and we had no concerns about hand hygiene practice.

**Environment and equipment**

The department shared resuscitation equipment with the outpatient department located through a set of double doors. Checking of the resuscitation equipment was the responsibility of the outpatient department. The department however, did provide an emergency box for the visiting CT and MRI scanners that came to the hospital weekly. The scanners were provided by a private company but consumables were provided by the trust. The emergency box contained emergency drugs as well as medicines to support people having a diabetic episode. We checked the box and all the medicines were in date and stored safely and correctly.

There was clear signage outside and around the department to warn staff of the risks of radiation. X-ray rooms had illuminated signage to inform patients when it was safe and unsafe to enter. There were no MRI or CT scanners in the department. The signage was clear, visible and appropriate to the needs of the department.

All staff were allocated a dosimeter to wear. These were sent away regularly for monitoring and assessment. Any concerns with abnormally high doses were highlighted to the member of staff responsible. We spoke with this member of staff who described to us the action they would take if a dosimeter showed an abnormal reading. This was in line with the trust process.

All staff had lead aprons to protect them from over exposure to harmful rays. There were also aprons available for patients such as pregnant women when an x-ray was deemed as necessary, and parents or carers so they could accompany a patient in to the x-ray room. We saw evidence that the protective garments were checked and removed from service when no longer offering viable protection.

We looked at COSHH (Control of substances hazardous to health) policies and found them to be in date. Any substances hazardous to health such as cleaning products were safely stored. The department did not use any specific radiology related contrast media on this site.

Equipment in the department was maintained in line with manufacturer requirements. There were maintenance and repair contracts in place. The medical electronics team within the trust was also able to carry out some repairs to broken down equipment. GDH had not experienced any significant problems with mechanical breakdowns.

The department had business continuity plans in place to manage mechanical breakdown or IT system failures such as cyber-attacks. These were tested when the trust fell victim to a national cyber-attack. Staff explained the process and told us the department continued to function using analogue images rather than digital ones.

**Assessing and responding to patient risk**

Policies, procedures and local rules were in place for radiology. We checked and these were all in date and displayed around the department.

There was a specific process in place for escalating unexpected or serious findings. This involved the radiographer requesting an urgent report and the reporting radiographer/radiologist calling the clinician who referred the patient to highlight the findings. However, we found one example of a delayed diagnosis because MRI results had not been escalated appropriately leading to a two month delay in the patient receiving their diagnosis and starting treatment.
The manager confirmed the trust had arrangements in place to seek advice from an external Radiology Protection Advisor (RPA) in accordance with relevant legislation. The hospital had a service level agreement (SLA) in place with the RPA at a neighbouring trust.

The head of general radiology told us the RPA was easily accessible through regular meetings or telephone.

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. We saw evidence of this happening.

Radiation protection information was available in a folder and staff had all signed to confirm they had read it.

All staff were observed to be wearing body dosimeters (dose meters) on the front of their torso. A radiation dosimeter is a device that measures exposure to ionizing radiation. 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 observed diagnostic reference levels (DRLs) were on display in the X-ray rooms. Risk assessments, including COSHH risk assessments, were all up to date.

Staff described how they would ensure pregnancy tests were performed for patients aged between 12 and 55 who were unsure of their pregnancy status. We saw pictorial representations were available for people whose first language was not English.

Imaging requests, which included pregnancy checks, were scanned into the patient’s electronic records. There were referral criteria which had to be met before a referral was accepted. Not all clinical staff could make a referral.

Systems and processes for the management of deteriorating patients were well established at the GDH site for both adults and children. Patients who deteriorated received initial care on site and were transferred by ambulance to the closest A&E or appropriate other service if required.

**Allied Health Professional Staffing**

**Vacancy rates**

There were no Radiographer staffing vacancies at Goole Hospital.

**Turnover rates**

The trust has an annual turnover target of 9.4%.

Turnover rates data provided by the trust for staff in diagnostics cover only Goole District Hospital, figures are provided below, turnover targets were met at the site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goole District Hospital</td>
<td>0.00</td>
<td>3.63</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

A turnover rate of 0% was reported at the site for staff working in diagnostics at Goole District Hospital.
Hospital. We confirmed this when we spoke with staff who told us all staff had been in post for a long time, nobody had left and nobody new had started. They told us staffing at GDH was very stable.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

The trust had a sickness target of 4.7%. Within diagnostics, the trust had a low sickness rate for allied health professionals. Staffing had been at full complement every month other than April 2017 and May 2017. The department met the trust target.

Bank and agency staff usage

Information on bank and agency staff usage provided by the trust did not include allied health professional staff working in diagnostics and imaging.

We spoke with staff and the manager of the department. They told us that if the department was at risk of being short staffed, a radiographer from Scunthorpe came over to cover.

Both the manager and staff told us there was an induction process within the trust for all new staff and a local induction programme for new staff to the diagnostics department. However, there had been no new staff in the department for a long time and any staff who came over from Scunthorpe had already worked in the department at Goole with one of the regular staff before working alone there.

Staff never worked alone on the Goole site. There was always at least a radiographer and a health care assistant together at any one time.

Medical staffing

The trust reported their medical and dental staff numbers below, as of January 2018 and January 2017. No medical staff were reported at Goole District Hospital. This was because radiologists were based on one site but worked and reported across all sites as required.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana, Princess of Wales Hospital</td>
<td>11.45</td>
<td>6.33</td>
<td>11.57</td>
<td>4.90</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>11.98</td>
<td>6.73</td>
<td>11.98</td>
<td>6.43</td>
</tr>
</tbody>
</table>

*relates to staff that had a location of ‘trust wide’ in the RPIR

Medical staffing rates Diana, Princess of Wales Hospital were 55% in January 18, and 56% at Scunthorpe General Hospital. Staffing rates were higher than the previous year at both sites however still very low.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

We requested the Radiology Benchmarking Dashboard Report of the trust. This was for the 2016/2017 outturn position. Of all the trusts who submitted data, this trust had the highest consultant radiologist vacancy rate.
The trust had significant problems recruiting radiologists despite actively trying to recruit both within the UK and worldwide.

At the time of the inspection, the department was outsourcing some of its routine and straightforward reporting to two external companies. If urgent advice or reporting was required out of hours, staff accessed one of the outsourced companies. However, a number of trust radiologists also had reporting stations at home and could read x-rays and scans from home if a report was needed urgently.

The trust told us that approximately 25% of CT and 16% of MRI scans were currently outsourced to other organisations for reporting at the time of our inspection.

The trust had an induction programme in place for new medical staff and there was a local induction programme within radiology.

**Vacancy rates**

For all staff in diagnostics and radiology

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scunthorpe General Hospital</td>
<td>61.55</td>
<td>143.76</td>
<td>42.8%</td>
</tr>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>69.92</td>
<td>138.6</td>
<td>50.4%</td>
</tr>
<tr>
<td>Trust wide*</td>
<td>42.4</td>
<td>257.3</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

*relates to staff that had a location of ‘trust wide’ in the RPIR

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

Turnover rates data provided by the trust do not include information on medical staff assigned to diagnostics.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

Sickness rates data provided by the trust do not include medical staff working in diagnostics.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

The bank and locum staff usage within diagnostics across the trust is shown below: All medical staff worked across all trust sites.

**Trust level**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Bank</th>
<th>Locum</th>
<th>Unfilled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>0 (0%)</td>
<td>253 (94%)</td>
<td>15 (6%)</td>
<td>268</td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3  Page 726
In diagnostics, from February 2017 to January 2018, a total of 253 shifts unfilled by substantive staff (94%) were filled by locum staff. There were 15 shifts (6%) that remained unfilled.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records

The department used electronic records and digital images accessible to all appropriate staff for viewing. Reports were available digitally and were part of the electronic patient record.

We looked at the record keeping system used in the department. It was linked to the patient’s main records and the Accident and Emergency department records system. The system made sure all relevant fields of information were completed and that results were easily accessible to relevant personnel.

X-ray results were emailed or posted to GPs automatically however the timeliness of this was dependent upon how quickly the x-ray or scan was reported. Reporting times were a KPI of the trust and were consistently monitored and reported upon.

Medicines

The diagnostics department at Goole had a limited supply of drugs mainly for use in emergencies. These were stored appropriately and securely and regularly checked to ensure they were in date.

The department did not use contrast media and therefore there was no need for PGDs (patient group directives).

If patients required pain relief, this was administered prior to them attending the department.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From March 2017 to February 2018, the trust reported no incidents classified as never events for diagnostics.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in diagnostics which met the reporting criteria set by NHS England from March 2017 to February 2018.

The incident was classified ‘Diagnostic incident including delay meeting SI criteria (including failure to act on test results) and occurred in September 2017. The incident did not take place at Goole Hospital.
We spoke with staff about incidents. They could describe to us the process for reporting incidents electronically. They understood the type of occurrences they must report, relating to radioactive materials, public and patient safety and staff safety.

Staff told us that if they reported an incident, they received an acknowledgement and sometimes feedback depending on the severity of the incident.

The diagnostics and radiology department across the trust produced a regular newsletter where incidents, complaints and concerns were highlighted along with any changes to practice. The newsletter was also used as a method of communicating any external safety alerts to staff. These alerts were also emailed to staff and discussed at team meetings.

Staff understood the principles of duty of candour, being open and honest and told us that if they made a mistake, such as an incorrect x-ray, they would inform the patient and then report it as an incident. Duty of candour was used in diagnostic services across the trust, four times from February 2017 to January 2018. The information was not broken down by site.

Is the service effective?

Evidence-based care and treatment

Nutrition and hydration

The department had water fountains available for patients to access cold water.

There were café facilities close by within the hospital which patients and relatives could access.

If staff had concerns about a patient who had not eaten and had a health condition such as diabetes, they could provide a light snack, however staff told us this almost never happened as patients came prepared and waits in the department were usually short.

Pain relief

The department held few medicines and generally did not administer pain relief for patients.

Staff asked patients about their pain levels and tried to ensure any scanning was carried out in the least painful way.

Patient outcomes

We discussed discrepancy meetings with staff and the manager. They told us that discrepancies were discussed with staff and meetings held at least bimonthly in line with the Royal College of Radiologists guidance.

If there were particular concerns about the performance of individual staff, these were addressed by the manager with the individual.

The trust employed an ISAS (imaging services accreditation scheme) assessor however they
were not currently in a position to apply for accreditation due to trust wide staff shortages and reporting delays. However, the trust was aware of the ISAS requirements and working towards them.

We asked the trust for evidence of ongoing clinical audit within diagnostic services. Evidence sent to us showed that the last clinical audit was undertaken in 2017/2018 and related to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). There was no clinical audit related to radiology scheduled for 2018/2019.

We requested the Radiology Benchmarking Dashboard Report of the trust. This was for the 2016/2017 outturn position. The report showed that the trust had fewer than the average CT scanners per 100,000 patients and fewer that the average MRI scanners per 100,000 patients. This corroborated what the trust was already aware of, that they needed more scanners to meet ever increasing demand.

Demand on the department had continued to grow in each modality other than PET scanning over the past five years and the trust had one of the highest levels of CT scans per 100,000 bed days in the country.

The trust had a rate of 2100 examinations per WTE staff. This was more than the average and showed that staff at the trust were examining more patients than colleagues at other trusts.

Of the trusts who submitted data, this trust was seventh in the list of highest outsourcing trusts with 7% compared to an average of 4%. The highest trust had an outsourcing rate of 26%. This trust could not meet the reporting demands of the examinations in carried out. There was an impact on patients because patients had to wait longer for the results of their scans.

**Competent staff**

**Appraisal rates**

From April 2017 to January 2018 85% of staff reported by the trust to be working in diagnostics at the trust had received an appraisal compared to a trust target of 95%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Appraisal completion</th>
<th>Trust target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>7</td>
<td>12</td>
<td>58.3%</td>
<td>95.0%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>31</strong></td>
<td><strong>74.2%</strong></td>
<td><strong>95.0%</strong></td>
</tr>
</tbody>
</table>

Goole District Hospital had an appraisal completion rate of 74.2% which did not meet the trust’s
target; however, both medical support staff at the site were appraised within target.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff we spoke with at Goole told us their manager was good at making sure they had appraisals and general support within their roles.

Staff said annual appraisals were supportive and worthwhile.

Staff had received training in supporting patients with dementia and challenging behaviour and therefore patients with these conditions could be supported in the department. Staff told us they could ask for additional support if it was required.

The department at Goole rarely used bank or agency staff however, staff came across from the Scunthorpe site to cover annual leave and sickness. These were regular staff from the trust who were familiar with the IT systems, procedures and policies of the department. However, there was a local induction in place to ensure staff were oriented with the department and familiar with where supplies and equipment were stored.

Patients who attended the Goole department were on the whole well, other than an injury however all staff had undergone training to identify if patients were deteriorating and how to access further support for the patient if required.

Multidisciplinary working

The department at Goole worked with the outpatient’s department and specialties to provide x-rays for patients.

The department at Goole was small and although it worked with other departments there were no reporting radiographers on site. Radiologists occasionally worked on site at Goole, however they could report on films from any location that had a reporting station therefore attendance at Goole was not necessary.

Radiologists who worked at Goole also worked across the trust and attended multidisciplinary meetings about patients held on the other two sites. These meetings discussed patient diagnoses and treatment options with specialists such as surgeons and oncologists.

The Goole site did not offer any one stop screening services in conjunction with other specialties however, these were offered at other sites within the trust.

Seven-day services

The radiology department at Goole and District Hospital was open from 9.00 until 17.30 Monday to Friday and from 10.00 until all patients had been examined on Saturdays. The department was closed on Sundays.

Patients needing an x-ray outside of the opening hours could go to one of the other sites at Scunthorpe or Grimsby.

The department has a visiting CT scanner and a visiting MRI scanner on certain days during the week for patients who preferred not to travel to one of the other trust sites.

Health Promotion

The department had posters and leaflets to promote patient good health, such as about stopping
smoking, healthy diet, child and adult safeguarding.

We asked staff if they spoke with patients about promoting good health. They told us they would only intervene if the patient asked for advice or if they thought the patient was in immediate danger or harm.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff in the department had completed Mental Capacity training. The compliance rate (including staff from Scunthorpe General Hospital) was 87%.

We spoke with staff about how they obtained consent form patients who had learning difficulties or were living with dementia. They told us if the patient was unable to identify themselves they would not perform the examination

The service at Goole provided plain film x-rays only and therefore patients were not required to complete a consent form. However, verbal consent was obtained from patients. The process included staff informing patients of the risks of having an x-ray and the contraindication of x-raying when patients had some conditions or were pregnant.

When a patient was pregnant or suspected they were, staff discussed the risk of an x-ray on the unborn child and supported patients to make a decision. Staff also offered patients the option of lead apron protection of the abdomen in cases when an x-ray was necessary.

Inpatients who required an x-ray had their identity checked from their wrist band and against the x-ray referral. The staff did not formally document consent but used implied consent.

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**Is the service caring?**

**Compassionate care**

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

**Emotional support**

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

**Understanding and involvement of patients and those close to them**

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

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**Is the service responsive?**

**Service delivery to meet the needs of local people**
The department was on the ground floor of the hospital on a single storey with wide doors therefore it was easy for patients and relatives to access. It was well signposted and easy to find.

There was sufficient car parking on site to meet the demands of the hospital.

Although there was no specific children’s waiting area, there were some toys to keep children amused while they were waiting.

The department had fixed opening hours however the management team had looked at the times of most demand and when the department was least used and made a decision to close the department overnight. X-rays were available over night at other sites in case of emergency and the department was open at the times when demand was at its highest.

We asked staff about long waits in the department. They told us that it was rare for patients to have long waits however if there were delays, they would inform patients of the delay and the reason. There was no electronic screen informing patients of delays however radiographers and health care assistants were frequently in and out of treatment rooms and updated patients as they needed to.

**Meeting people’s individual needs**

The department provided information for patients about treatments offered by the radiology department. These were also online for patients to access. We checked all of the leaflets and found that seven had passed their review date. Additionally, there was no information about how to access the leaflets in other formats such as large print, Braille, easy read or other languages.

Staff told us they could access interpreters either in person or by telephone if needed however they also told us that this was rarely needed in Goole.

The department could accommodate bariatric patients for x-rays if required and the waiting area had a larger seat.

There was no specific quiet area for patients with sensory needs or who did not like to be in busy areas due to health conditions however, we asked staff how they would support such patients and they told us patients would be supported to be seen quickly.

**Access and flow**

**Diagnostic waiting times (percent waiting 6+ weeks)**

From June 2017 to January 2018, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average, following an upward trend over the period. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England.

---
This Trust \hspace{1cm} England Avg.
Patients had long waits to have their examinations reported upon. The trust had a backlog of reporting due to the shortage of radiologists in the department. At the time of our inspection, the backlog for each modality trust wide was as follows:

- Plain film x-rays, 1805 report backlog, longest report delayed by five weeks.
- CT, 551 report backlogs, longest report delayed by seven weeks.
- MRI, 353 report backlogs, longest report delayed by 10 weeks.
- Ultrasound, 12 report backlogs, longest report delayed by two days.

The impact at Goole District Hospital was on plain film x-rays as this was the only modality the site conducted where there were significant delays. There was no information available for GDH site only.

We discussed inpatient demand with managers in the trust. They told us that inpatient referrals were given priority, particularly from A&E, then the wards. Priority was then given to two-week urgent referrals, urgent referrals and then routine referrals.

We asked staff how scan referrals were prioritised. Staff told us decisions were made by administrative and radiography staff using specific criteria however radiologists were also consulted to make sure no urgent referrals were missed. This process was used across the trust.

The management team at GDH monitored performance against local and national key performance indicators (KPIs). We requested evidence of this and the trust provided us with the monthly report for each site and modality. The report was comprehensive and monitored waiting times, reporting times, staffing levels, locum and bank use, a financial summary, did not attend (DNA) rates, number of referrals, demand and activity increases and any exceptional events to note. The report was discussed within the senior management team to ensure they were aware of any concerns or problems the department was encountering.

Managers told us that demand on radiological services was increasing significantly year on year leading to pressure on all radiology services although particularly MRI and CT.

When patients DNA, the department offered one further appointment, however DNA added pressure to services. The combined DNA rate for GDH and SGH was 1.7% for CT scans and...
2.4% for MRI scans.

In March 2018, the routine waiting time for the Ultrasound department was up to four weeks and 85% of patients on the 31/62 day pathways were being seen within seven days at Goole and Scunthorpe. (Figures reported together as managed as one team).

In March 2018 GDH saw 100% of CT and MRI patients receive scans within target and there were 77 patients waiting up to seven days for either a CT or MRI scan.

The trust as a whole had encountered problems with mechanical breakdowns of both MRI and CT scanners and the risk register showed that some scanners were classed as 'end of life'. This meant that the manufacturer no longer made spare parts. When the machinery broke down, new spare parts were not always available and the trust needed to use recycled spare parts that did not always have a long life either.

Over the six months from November 2017 to April 2018 there had been one mechanical breakdown leading to cancellations of examinations at Goole District Hospital. This was of one of the visiting MRI scanners. The breakdown led to the loss of 22 outpatient scan appointments. It should however be noted that although the patients were trust patients, the service was outsourced to a private company who provided the mobile scanner.

Staff told us that once patients arrived at the department, waiting times for treatment were short because most of the treatments were straightforward. If there was a delay, staff told us they would inform patients how long this was likely to be.

**Learning from complaints and concerns**

From 7 February 2017 to 7 February 2018 there were nine complaints about diagnostics, all for radiology. The trust took an average of 55 working days to investigate and close these complaints.

The trust has a target to close complaints within 30 working days and a further target of 45 working days. Only two of the nine complaints in diagnostics were closed within 30 working days and with four closed within 45 working days.

The trust has a target to close more complex complaints within 60 working days. Five of the nine complaints (complex and non-complex) were closed within this target.

The most common subjects complained about in diagnostics services were patient care (five complaints), appointments (two complaints) and communications and admissions/discharges with one complaint each.

**Goole District Hospital**

There were no complaints about GDH.

*(Source: Routine Provider Information Request (RPIR) P61 Complaints)*

**Summary of compliments**

From 7 February 2017 to 7 February 2018 the trust received 30 compliments for diagnostics.

**Goole District Hospital**

There was one compliment for Radiology received.
There was information in the waiting room informing patients about how to make a complaint or pass on a compliment to staff in a formal way. Patients were encouraged to give feedback to improve the service provided.

Lessons learned were fed back to staff on a regular basis at team meetings and via a radiology newsletter that also contained information about incidents, new policies and procedures, changes and advances in practice and interesting information about the department trust-wide. Staff at GDH had to sign to say they had read and understood the newsletter contents.

**Is the service well-led?**

**Leadership**

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 clinical director and associate chief operating officer. Clinical support services also had a business manager and two business support managers.

Each modality also had a service manager who oversaw the day to day functions of the department. We met with most of these staff during our inspection. Modality managers were aware of the challenges facing the department and the KPIs they were required to meet. They understood the challenges in relation to performance, demand, staffing and risks.

Staff we spoke with during the inspection at GDH told us that they felt well-led at a local level and they had no concerns with their line manager. They told us they were approachable and supportive.

Staff we spoke with told us they knew who the new chief executive was and felt that the trust had changed in a positive way since our last inspection.

**Vision and Strategy**

We interviewed the management team during the inspection. In relation to GDH, there were no significant concerns about the department. The concerns within diagnostics and radiology were more focussed on the two other sites of the trust.

Staff had a clear vision for the GDH department which was to continue to support the other departments across the trust within their working capacity to ensure that services met the needs of the local populations.

Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to try to manage demand.

The management team were working to ensure that the service was sustainable for the future.

**Culture**

We found there was good collaborative working between the staff teams at Scunthorpe and GDH; however, these services did not link with the Grimsby site. The head of general radiology managed the Scunthorpe and Grimsby sites and staff from Scunthorpe sometimes worked at Goole to cover annual leave and sickness.
Staff we spoke with told us it was a “positive culture” with good teamwork. They said there were no problems escalating any concerns or worries at GDH.

The team at GDH was small, friendly and had worked together for many years therefore there was a feeling of understanding and support amongst work colleagues.

Staff worked well together and there was obvious respect and rapport between different staff groups within the department.

Staff spoke positively about the service they provided for patients and were aware of the importance of providing a quality service with a positive patient experience.

**Governance**

Governance arrangements were in place within radiology. The clinical support services (CSS) division held monthly meetings where performance and governance were discussed. Information from these meetings was shared with front line staff both in person and via email minutes.

The department held medical exposures committee meetings and radiation protection committee meetings. These were recorded and shared with relevant staff.

The service held monthly team briefing meetings at the GDH 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 at the team meetings. Comments, compliments, complaints, audits and quality improvement were also discussed. This information was also shared in a regular newsletter which was printed off and kept in the staff break room for staff to read at their convenience. All staff had to sign to say they had read the newsletter.

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 saw examples of this during the inspection as some radiographers showed us their feedback, mostly positive but with some constructive advice.

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 a service level agreement was in place. The RPS was a radiographer based within the trust.

**Management of risk, issues and performance**

The hospital had a risk register in place and managers updated this accordingly. Managers were aware of the risks within their departments and were trying to manage them.

None of the risks on the radiology risk register related specifically to the GDH site only. Risks to waiting times, reporting times and staffing were reported as trust wide diagnostics and radiology risks.

**Information Management**
The department collected information used to monitor and manage performance. There were measures in place to monitor and manage the performance of the department against local and national indicators. These were observed by the management team.

The department used several IT systems to collect and share information such as x-ray and scan results.

Staff could access patient information using an electronic system. This included information such as previous x-rays and scans.

Some information such as scan and x-ray reports were shared with GPs however this was done with the agreement of patients.

The trust had information governance policies and procedures in place to ensure that information was stored securely and protected patients’ privacy and security.

Staff were aware of their responsibilities in relation to data protection and making sure that information was accurate and managed securely. Data protection principles were followed within the department at GDH.

Information governance including data protection and confidentiality was monitored and any incidents reported appropriately.

**Engagement**

The trust did not supply us with any evidence to demonstrate engagement with patients who used the diagnostic and radiology services at GDH prior to the inspection however have since provided evidence of annual inpatient and outpatient surveys for 2017 and 2018. Each had an associated action plan that outlined those responsible for completing actions.

The trust had begun to work with staff across the staff to look at culture, engagement and equality and diversity across the trust. Staff at GDH were part of this engagement.

**Learning, continuous improvement and innovation**

Staff at GDH were unable to provide us with any examples of innovation in the department.

Staff told us they could access training that was related to their role however some staff felt frustrated at not being able to progress within the department and achieve promotion within plain film radiology. This was common across all three sites at the trust.
Community health services for adults

Facts and data about this service

Northern Lincolnshire and Goole NHS Foundation Trust provides a wide range of adult community and therapy services to a population of more than 350,000 people across North and North East Lincolnshire and the East Riding of Yorkshire.

Community health services for adults are provided by the Division of Community and Therapy Services and had been established as part of the “Fit for the Future” consultation in April 2011. It has a budget of £27 million and has approximately 700 whole time equivalent staff.

It provides services at around 50 locations, which carries out 28 specialties for this core service. The regularity of clinics ranges from one a month to 56 per month at some locations.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The service offers treatment to adult patients in a variety of health and social care settings as well as in patient’s own homes and provides the following services:

- Chronic pain
- Community matrons
- Continence
- Core rehabilitation
- District nursing
- Equipment services and store
- Learning disabilities
- Nutrition and dietetics
- Occupational therapy
- Orthotics
- Physiotherapy
- Podiatry
- Rehabilitation medicine service
- Speech and language therapy
- Tissue viability and chronic wound care
- Unscheduled care team
- Wheelchair services

Community nursing services are provided within three care networks. This service covers the population of North Lincolnshire only.

The therapy team provides services in both the acute and community settings and covers both the population of North East and North Lincolnshire.

During our inspection, we spoke with 46 members of staff including administration staff, nurses, managers, therapists and, nursing and therapy assistants. We observed staff providing care in clinics and at patient’s homes. We spoke with 22 patients and relatives and looked at 12 patient records. We also reviewed performance information from, and about, the trust.
Is the service safe?

Mandatory training

Mandatory training levels had improved since our last inspection. Most staff we spoke with were up to date with their mandatory training and told us that it was easy to access training sessions including accessing it online. Staff received an email when they were due to book onto the training and when they were overdue. Smaller teams said that it was sometimes difficult to get cover for their work and some nursing staff in the care networks told us that they had to cancel mandatory training sessions due to work pressure over the winter period. All therapy staff we spoke with told us that they were up to date with their mandatory training.

Compliance with meeting trust targets had improved. We noticed that the trust had reduced the target from 95% to 85% since our last inspection.

Mandatory Training completion

A breakdown of compliance for mandatory courses from February 2017 to January 2018 for nursing staff in community adults is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>128</td>
<td>137</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>126</td>
<td>136</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>126</td>
<td>137</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>122</td>
<td>137</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>116</td>
<td>133</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>119</td>
<td>137</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>117</td>
<td>137</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>117</td>
<td>137</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>101</td>
<td>120</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>101</td>
<td>137</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff achieved the target for eight of the 10 eligible mandatory training courses.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff we spoke with had a good knowledge and understanding of the trust’s safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.

The trust safeguarding lead was supported by a team of adult and child safeguarding nurses and a named nurse for the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS). The safeguarding team provided training to staff, which included learning from safeguarding incidents.

Staff told us the team were very helpful if they contacted them for advice with a safeguarding issue or concern.

Compliance with safeguarding training was high for staff in community services for adults, exceeding the trust target of 85%.

Safeguarding Training completion
The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from February 2017 to January 2018 nursing staff in community adults at trust level is below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>122</td>
<td>137</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>121</td>
<td>137</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>118</td>
<td>137</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff achieved the target in all three of the safeguarding modules.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust only provided referral data at a provider wide level so we are unable to break it down to core service.

(Source: Routine Provider Information Request (RPIR) – Referrals tab)

Cleanliness, infection control and hygiene

All areas we visited appeared visibly clean. We saw that personal protective equipment such as gloves, aprons and alcohol gel were available for staff and used appropriately. We saw staff washing their hands and they adhered to the trust policy of bare below the elbows.

In clinics and at patient’s homes we observed staff demonstrating good aseptic technique when redressing wounds.

We saw correct segregation of waste in clinics with sharps bins correctly assembled and labelled. Staff visiting patients at home disposed of their clinical waste at the patient’s home, placed sharps in a sharps bin, and transported this back to the base in the boot of their cars. We noticed that staff did not always secure the temporary closure on the sharps bin and it was not contained within a rigid red UN approved box as per the trust policy.

At the Assisted Living Centre in Grimsby, we saw that there was a good process in place for the decontamination of reusable equipment. There was a clear flow through from dirty to cleaning areas and then to a clean storage area. The building was divided into five zones for cleaning audits. Staff audited each area twice a week and carried out daily checks.
There was an annual infection prevention and control audit programme for community and therapy services, which included yearly hand hygiene audits for all staff, urinary catheter practice for nursing staff and an environmental audit for all clinical areas. The results of the audit determined when the area would be re-audited. For example, if the audit score for an area was 95% or above, it would be audited every three months. Those with scores below this were required to complete audits monthly until they achieved scores of 95% and above.

Compliance with infection control training for nursing staff in community adults was 85%, which met the trust target.

Environment and equipment

The Trust had two integrated community equipment stores, one at the Assisted Living Centre in Grimsby and the other at the Community Equipment Store in Scunthorpe. We visited the Assisted Living Centre in Grimsby and found the store was well organised with good supply of mattresses and other equipment used for pressure ulcer prevention. There was a clear process for managing the stock using an electronic system. Every piece of equipment was bar coded and tracked throughout the process of maintenance, repair or cleaning and was recorded as it came into and out of the store.

District nurses, occupational therapists and physiotherapists were able to order equipment using an online form. Staff we spoke with reported no issues with obtaining the equipment they needed for patients.

A weekly clinical expert panel was held to discuss and approve specialist items.

The tissue viability lead had completed an audit of equipment and worked with another provider on the patch to review the type and volume of equipment stored. Equipment was now standardised at both stores to ensure there was adequate equipment to meet demand.

We checked 10 pieces of equipment including bladder scanners, hoists and plinths. We found all were in good working order and had been safety tested and checked according to manufacturer’s recommendations.

The continence team had ordered bladder scanners and the model had been changed by the procurement team without consulting the staff.

Assessing and responding to patient risk

We saw that patient risk assessments were recorded in the patient record on the electronic records system. Patients were assessed for risk of pressure damage and malnutrition. Staff used the Malnutrition Universal Screening Tool (MUST) to identify patients at risk of malnutrition.

We were not assured that the risk assessment tool for pressure damage was a nationally recognised assessment tool. It was a set of questions for the nursing staff to consider and tick to help them decide if the patient was at risk. There was no scoring system or guidance for staff on what the risk level was, based on the responses to the questions and what action they should take to reduce any risk. We discussed this with the tissue viability lead nurse who informed us that community nursing services were planning to move to a new pressure risk assessment tool currently used in the acute hospitals. This tool was more effective and used a ‘red, amber, green’ (RAG) rating to identify the level of risk and the appropriate action to take.

There had been an increase in avoidable pressure damage within the service, which had resulted in six serious incident investigations. These were ongoing at the time of our inspection. The tissue viability lead nurse was involved in the investigation of pressure ulcers and a full root cause
analysis was conducted for every incident of grade three or four pressure ulcer to ascertain whether it was avoidable or unavoidable.

In response to this increase in pressure damage the trust had recently (April 2018) appointed a temporary post of quality lead for pressure ulcer prevention. The quality lead was working with the improvement academy to reduce the number of pressure ulcers in community. As part of this work, the care networks were planning to roll out ‘react to red’ pressure ulcer prevention training to staff in residential homes.

Staff were able to refer patients to the tissue viability lead nurse if they needed advice on how to manage a high risk patient or advice on wound care. Equipment was available for patients identified as at risk of pressure damage.

There was no specific falls assessment process used by the community nurses. We were told that falls risk was part of the environmental assessment and if the patient had a history of falling, or they observed the patient stumble or fall, an immediate referral to the integrated therapy team would be made.

Community nursing staff used a RAG rating system to prioritise patient need. If there were issues with staffing, for example a member of staff was off sick or business continuity plans were instigated due to bad weather, patients coded as red would be visited as a priority. These patients had complex needs and may need a daily visit from nursing staff, for example, for the administration of insulin.

Nursing staff fed back daily to the team leader if extra visits were warranted and they contacted the patient’s GP or the unscheduled care team to escalate a patient who was unwell or whose condition deteriorated.

The unscheduled care team had good knowledge and awareness of sepsis. All members of the team had a sepsis flow chart to follow which had been developed by the clinical development team and was in line with the trust policy on sepsis. The team had a direct hotline into the accident and emergency department.

**Staffing**

**Nurse caseloads**

<table>
<thead>
<tr>
<th>Team</th>
<th>Average caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Network Community Nurses</td>
<td>130</td>
</tr>
<tr>
<td>West Network Community Nurses</td>
<td>128</td>
</tr>
<tr>
<td>South Network Community Nurses</td>
<td>103</td>
</tr>
<tr>
<td>Complex Care Matrons</td>
<td>35</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Caseloads tab)*

There was no national benchmarking of caseloads for community nurses and complex case matrons, however the service was in the process of reviewing a weighting caseload tool previously used in health visiting services to see if this could be applied to a community nursing caseload.

Staff told us there was no maximum number of patients allowed on a caseload and the team leaders reviewed caseloads with the district nurses regularly. All patients on community nurse caseloads were RAG rated depending on complexity.
We found staffing issues in most of the teams we visited. There were high vacancies in some teams and the we saw in the divisional performance report that sickness levels for community and therapy services exceeded the trust target of 4% for every month from April 2017 to March 2018.

The South Care Network had a stable team and low vacancies. The matron told us the sickness rate in this team was 6.6% at the time of our inspection, which was higher than the trust target of 4.1%.

The sickness rate in the East Care Network was 27% at the time of our visit. The team leader was new in post and was working with the team to build resilience, as most sickness was stress related. The team had undergone two location changes and restructuring in the previous year and had found this challenging.

The West Care Network had no district nurse caseload holders at the time of our inspection. This was due to vacancies and long-term sickness. Plans were in place to recruit and develop current band 5 nurses into this role. As an interim measure, the team had been re-located with the South Care Network nursing team for support.

The care networks used bank nurses and assistants to cover for vacancies and sickness, but did not use agency staff.

The unscheduled care team’s role was to assist patients to remain in their own home or care home, if safe to do so, during an episode of acute illness. Since January 2018, eight of the 13 Advanced Nurse Practitioners had left the service. This meant there were insufficient staff to provide a 24-hour service seven days a week. In response to this the night shift had been discontinued on a temporary basis. A recruitment plan was in place and they had recruited five new staff. Existing staff were concerned that the new staff were not fully qualified practitioners and would therefore need support, training and upskilling. The new starters had been given staggered start dates to reduce the pressure on the existing staff.

The continence service was staffed by one band 7 specialist nurse (1.0 wte), one band 5 nurse (0.2 wte) and one administrative assistant (1.0 wte). There was a vacancy of one band 4 assistant. The specialist nurse told us that staffing hours had been removed from this service which led to service pressure and long waiting times for new patients. However, information provided by the trust indicated that there had been no reduction to the level of staffing since November 2016. Part of the role of continence specialist nurse was to deliver catheter training, however there was no capacity to deliver training due to the clinical demands of the service.

The Single Point of Access (SPA) team were fully staffed with one band 6 nurse and five band 5 nurses. Two staff were on duty at any one time covering the hours of 8am to midnight, seven days a week. The service also used bank and agency staff. Although there were no vacancies in the team, staffing levels were not sufficient to deal with demand on the service. Managers told us they had been given permission to over recruit because of the demand on the service.

There were a high number of therapy vacancies. Therapy staff told us it was difficult to recruit and retain therapists and there was a shortage of middle grades. Bank and agency staff were used to fill some gaps in service, however staff vacancies were having an impact on services to patients. For example, the Early Stroke Discharge team based at Diana Princess of Wales Hospital told us they were not always able to meet the Royal College of Physicians stroke guidelines in both timeliness and intensity of treatment due to insufficient staffing levels. In addition, there were long waits for community neuro therapy (five months) and community rehab medicine (six months) in North East Lincolnshire.

The trust had an incentive scheme to recruit newly qualified therapists. Student therapists were interviewed at the end of their second year and, if successful, they were offered a guaranteed
band 5 post and given £1000 towards their training. They were also offered work as an assistant during the university holidays.

**Planned v Actual**

Details of staffing levels within community services for adults by staff group as at January 2018 are below.

**Community adults total**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Planned staff WTE</th>
<th>Actual Staff WTE</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nurses</td>
<td>121.9</td>
<td>116.3</td>
<td>95%</td>
</tr>
<tr>
<td>Qualified AHPs</td>
<td>177.11</td>
<td>155.54</td>
<td>88%</td>
</tr>
<tr>
<td>Support to doctors &amp; nurses</td>
<td>58.02</td>
<td>56.45</td>
<td>97%</td>
</tr>
<tr>
<td>Others</td>
<td>154.07</td>
<td>151.84</td>
<td>99%</td>
</tr>
<tr>
<td>Total</td>
<td>516.5</td>
<td>484.93</td>
<td>94%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancies**

The trust set a target of 6.3% for vacancy rates. From February 2017 and January 2018, nursing staff had an annual vacancy rate of 8.1%. This was higher than the trust target.

(Source: Routine Provider Information Request (RPIR) – Vacancies tab)

**Turnover**

The trust set a target of 9.4% for turnover rates. Nursing staff had an annual turnover rate of 7.9% from February 2017 to January 2018, which was lower than the target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness**

The trust set a target of 4.1% for sickness rates. Nursing staff had an annual sickness rate of 6.4% between February 2017 and January 2018, which was higher than the target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Records**

Patient assessment and treatment records were held on an electronic records system with the exception of some therapy records, which were still recorded in paper format. Community nursing patient records were electronic with a minimal paper record, which was left in the patient’s home and contained contact details for the care networks.

Staff were able to view and share patients’ information with the majority of GP practices, who used the same electronic system. They were also able to access the records system in the acute hospitals.

We looked at 12 patient records, including six electronic and six paper records. We found that
they were securely stored and appropriate assessments and care plans were completed accurately.

The division carried out an annual re-audit of generic record keeping standards. We saw the report for 2016-2017, which highlighted areas of good compliance and areas for improvement. There was an action plan to improve the areas that needed improvement.

In addition to the annual audit, care network team leaders told us they carried out a monthly record audit on seven sets of case notes and the results were submitted to the operational matron. Any relevant findings were fed back to the team and if necessary to individual members of staff.

At the previous inspection, there was limited evidence in records that patients had been asked about their religious or cultural beliefs. In the records we reviewed, six out of the 12 records had recorded patient’s religious or cultural beliefs.

Community nursing staff had introduced a structured way of recording information in patient records. They recorded situation/background/assessment/recommendation (SBAR). Staff told us this was useful in the handover of complex patients.

Medicines

Nursing staff in the care networks carried adrenaline in their domiciliary bags when visiting patients at home. Adrenaline stock was stored in a locked safe back at the office base. We checked the adrenaline and found it was in date with the exception of one vial in the safe. We pointed this out to staff and they immediately removed it for disposal.

We saw that nursing staff checked and recorded controlled drugs appropriately and gave clear instructions on disposal of the drugs to the family of a deceased patient.

A number of the complex care matrons and staff working in the unscheduled care team were non-medical prescribers. We were concerned that none of the prescribers we spoke with knew who the non-medical prescribing lead for the trust was and they had not been allocated a Designated Medical Practitioner (DMP) as per trust policy. This meant they had not received regular prescribing supervision.

Prescribers received a report on their prescribing from the National Prescribing Centre; however, they said it was not discussed or reviewed. This did not give us assurance that prescribing by practitioners was being monitored and they were prescribing using best practice and safely.

Prescribers carried their own prescription pads and staff told us they took them home to keep them safe and secure. We checked the trust policy, which said ‘It is the responsibility of the NMP to ensure security of the prescription pad at all times’. The service had an audit sheet which prescribers were required to complete. The sheet included questions on where the prescription pads were stored in working hours and out of working hours. We found no evidence that the service had completed a prescription pad audit in the last year, which meant they could not be assured of the safe storage and use of prescription pads.

Patient Group Directives (PGDs) were in place for the unscheduled care team for a number of medications, for example, flucloxacillin and prednisolone. PGDs were stored in a locked cupboard at the office base. We looked at ten PGDs and saw they were signed and up to date.

The service did not provide intravenous antibiotic therapy in the community. However, staff told us there were plans to move to this in the future.
Safety performance

Community health service for adults participated in the NHS safety thermometer. The data was monitored monthly in the community and therapies divisional performance report. The March 2018 report showed that between April 2017 and March 2018 harm free care was between 95.1% and 98.3%. This was better than the threshold set by the trust and the England average, which were both 95%.

We did not see this information displayed anywhere for staff to see, however one team leader told us it was discussed at team meetings.

Safety Thermometer

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are ‘harm free’ during their working day. For example, at shift handover or during ward rounds. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient’s own home, to measure, assess, learn and improve the safety of the care they provide. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

- The trust reported 35 new pressure ulcers, during the period February 2017 and February 2018.
- The trust reported 11 falls with harm between February 2017 and February 2018.
- The trust reported five Catheter & UTI’s between February 2017 and February 2018.
- Between February 2017 and February 2018, the trust recorded 4,311 cases of ‘harm free’ care.


Incident reporting, learning and improvement

Staff were aware of the importance of incident reporting and knew how to report an incident using the electronic reporting system. They said the trust encouraged them to report incidents.

Feedback and learning from incidents varied between teams. Some teams gave examples of shared learning from incidents. A locality matron told us they identified an increase in incidents relating to medication errors for a specific injection. In order to address this issue, the clinical development team had rolled out a programme of training for nursing staff and the number of incidents had reduced.

Some staff we spoke with were aware of the findings of an investigation into a serious incident involving community services. They told us lessons were learnt and implemented.

However, some staff said they rarely received feedback from incidents and other staff told us they received shared learning from incidents by email but there was no arena where they were discussed. The trust had introduced a standard team meeting template, which included incidents as an agenda item, however we reviewed the minutes of therapy and care network meetings and only one team was using the standard template. There was no evidence of discussion about incidents in any of the minutes we reviewed.
We did not find any evidence of how learning was shared wider than local teams.

The service monitored themes and trends from incidents and had identified an increase in pressure damage incidents. In response to this they had recently appointed a quality lead for pressure ulcer prevention.

All serious incidents were investigated using root cause analysis (RCA). We reviewed two serious incident investigation reports and found them to be thorough and comprehensive. They contained recommendations and an action plan to prevent a reoccurrence.

The trust circulated external safety alerts to staff via an email.

**Serious Incidents - STEIS**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in community services for adults, which met the reporting criteria, set by NHS England between, February 2017 and March 2018.

*Source: NHS Improvement - STEIS*

**Serious Incidents (SIRI) – Trust data**

From February 2017 to March 2018, trust staff in this core service reported five serious incidents.

*Source: Routine Provider Information Request (RPIR) – Incidents tab*

**Prevention of Future Death Reports (Remove before publication)**

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

The trust did not provide any data regarding the prevention of future death reports in relation to community health services for adults.

*Source: Routine Provider Information Request (RPIR) – P86 – Prevention of future death reports*

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents’ and provide reasonable support to that person.

All grades of staff we spoke were aware of the duty of candour and were able to give examples of when they would apply this.

**Is the service effective?**
Evidence-based care and treatment

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. We looked at several trust policies, for example ‘The Safe Management of Healthcare Waste’ and ‘Prescribing by Non-Medical Staff’. We found they were all within their review date.

There was a process to ensure that pathways and practice were in line with the National Institute for Health and Care Excellence (NICE) guidelines. The governance lead for community and therapies reviewed new NICE guidance and it was discussed at the governance group meeting. If appropriate to community and therapies, the group appointed a lead assessor to assess compliance and develop an action plan to achieve compliance.

We observed staff in the wound care clinic following a leg ulcer algorithm, which was in line with best practice and NICE guideline; Varicose veins: diagnosis and management (CG168).

The continence specialist nurse had led a task and finish group to develop care pathways and guidelines using evidenced based care. A catheter passport had recently been ratified and was in use.

The Early Stroke Discharge team based at Diana Princess of Wales Hospital told us they were not always able to meet the Royal College of Physicians stroke guidelines in both timeliness and intensity of treatment due to insufficient staffing levels.

Nutrition and hydration

We saw in patient’s electronic record that staff used the Malnutrition Universal Screening Tool (MUST) to identify patients at risk of malnutrition. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese.

Staff referred patients identified as at risk to the dietician. We saw an example of an appropriate referral in a patient’s record.

Pain relief

Pain scores were not routinely used by community nursing staff, however wound care assessment charts used a pain score 0-10 to record patients’ pain level.

We observed staff asking patients about their pain in the wound care clinic.

Patient outcomes

We saw evidence of staff recording and measuring patient outcomes in some of the services within community adults; however, we did not see a clear approach to monitoring, auditing and benchmarking the quality of these services and the outcomes for people receiving care and treatment.

Podiatrists used a pain assessment scale to measure the effectiveness of a patient’s treatment. This was evaluated at the end of the treatment as better, worse or the same.

Physiotherapists use the Berg Balance Scale and Modified Rivermead Mobility Index to measure individual patient outcomes.

Therapists in the care networks used the EQ-5D tool (a standardised measure of health status) to measure outcomes for their patients.
Staff we spoke with said they did not see reports from the outcomes they recorded to know how effective they were as a practitioner and as a service.

The urgent care service collected data to demonstrate their effectiveness in avoiding attendance to the Accident and Emergency Department.

Therapy staff participated in the Sentinel Stroke National Audit Programme (SSNAP)

The service did not participate in the National Intermediate Care Audit (NICA).

### Audits – changes to working practices

The trust have participated in three clinical audits in relation to this core service as part of their Clinical Audit Programme

<table>
<thead>
<tr>
<th>Audit</th>
<th>Successes</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record Keeping – July 17</td>
<td>High compliance in areas including the following:</td>
<td>Lower compliance regarding the following areas being recorded:</td>
</tr>
<tr>
<td></td>
<td>- Entries legible</td>
<td>- Religion/cultural beliefs</td>
</tr>
<tr>
<td></td>
<td>- Clinical record containing all relevant clinical information (incl. initial assessment, diagnosis)</td>
<td>- Allergy status</td>
</tr>
<tr>
<td></td>
<td>- Patients given relevant information</td>
<td>- Ethnic group</td>
</tr>
<tr>
<td>National SSNAP ESD/CRT 16/17 – June 17</td>
<td>- When patients receive therapy sessions the length of time of these sessions is on a par with national figures across the areas.</td>
<td>- Occupation</td>
</tr>
<tr>
<td></td>
<td>- Rehabilitation goals being set for SGH has remained at 100%.</td>
<td>- Next of kin</td>
</tr>
</tbody>
</table>
| Antibiotic Prescribing – July 17   | - 100% compliance in ensuring the prescriber was identifiable and documenting the indication for prescribing antibiotics. | - Improvement is required in both teams (unscheduled care team & matrons) in documenting the required information such as the dose, route, site of administration and advice given to the patient.
|                                    | - In comparison to the previous audit there has been an increase in the unscheduled care team recording allergy status. | - Documentation is also to be improved on the Patient Group Directive Document (used by unscheduled care team) as a signature was provided in none of the cases. |
|                                    | - Improvement in antibiotics being deemed clinically appropriate.          |                                                                          |

(Source: Routine Provider Information Request (RPIR) – Audits – Changes to working practices tab)

### Competent staff

The trust policy stated that community adult nurses/matrons and managers should access clinical supervision for a minimum of annually formally and informal supervision as required. Nursing
staff we spoke with said they rarely had supervision and some said they had not participated in one to one supervision for six to seven years.

Therapy staff (registered with the HCPC) were responsible for accessing supervision and maintaining personal records a minimum of twice per year (once every 6 months) to maintain compliance. Staff we spoke with confirmed that they were compliant with this and could describe different ways they received supervision such as group, peer and one to one.

**Clinical Supervision**

According to information supplied by the trust, compliance with nurse supervision was 72%, which did not meet the trust target of 95%.

(Source: Additional data request DR410)

**Appraisal rates**

From April 2017 to January 2018, 72% of permanent non-medical staff within the community services for adults’ core service had received an appraisal compared to the trust target of 95%.

**Community adults total**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals complete</th>
<th>Individuals required</th>
<th>Completion rate</th>
<th>Target</th>
<th>Met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>18</td>
<td>23</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>86</td>
<td>115</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>8</td>
<td>11</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>41</td>
<td>65</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

There were four practice educators within the three care networks to support staff education and development. The service supported nursing and therapy students on placement.

The Community and Therapy Services Division had a dedicated development team. The team had varied professional backgrounds and worked together to support all teams in their learning and development. The service had good links with local education providers and worked with them to develop training and education packages for staff. There were a number of staff completing apprenticeships and assistant practitioner studies.

We found that staff in the unscheduled care team and the complex case matrons had a varied range of skills. There was no specific skills framework. This meant that services to patient would be variable dependant on the skill set of individual member of staff. For example, only one member of staff in the UCT had the skills to close sutures so if they were not on duty a patient requiring this would have to go to the Accident and Emergency Department.
A member of staff working in the Single Point of Access (SPA) told us they had requested extra training on reviewing blood results as they felt this was an important skill needed to carry out their role effectively. Their senior manager had refused this training giving no reason and had not allowed the member of staff to explain their reasons for the training request.

The tissue viability team provided classroom based training on pressure ulcer prevention to all clinical staff. The trust had reduced the regularity of this training from three yearly to five yearly. There was no bespoke training for community staff, however the newly appointed quality lead for pressure ulcer prevention planned to develop this.

Several nurses were undertaking the district nurse qualification and four other staff had gained a place to train the following year.

The team leader for East Care Network had identified stress as a common theme in staff sickness and had attended stress risk assessment training in order to support staff.

We spoke to three locum therapy staff during the inspection and they all said they had received a thorough induction and felt well supported.

Therapy staff said they were able to plan in time for continuing professional development and managers had supported them with requests for relevant external training.

A newly qualified podiatrist said they had been allocated a mentor who they met with monthly for support.

**Multidisciplinary working and coordinated care pathways**

Staff we spoke with thought there was an improvement in integrated working, both in their services and in the trust overall.

Nursing and therapy staff working in the three care networks were co-located in the same office as social care workers. Staff said this had helped improve integrated working.

Staff in the SPA team said they had good links with mental health services and social services.

Staff were able to refer patients to specialist services for example the continence nurse, heart failure nurse and tissue viability nurse.

The community neuro team, which included the community stroke team, was a multidisciplinary team of occupational therapists, physiotherapists and assistants. Speech and language therapists contributed to this team as required.

Following a group session for patients with Parkinson’s disease, we observed staff discussing the specific care needs of each patient, how well they did that day and their future care plan. At the meeting, decisions were made on which member of staff would lead on the care package for each new patient.

Staff in the wound care clinic told us they worked closely with the dermatology service, which was provided by another organisation.

**Health promotion**

Staff documented the initial patient assessment on the electronic records system, which included questions on alcohol use and smoking. Patients could be signposted to services such as smoking...
cessation and alcohol support services when appropriate.

The wound care clinic provided patients with information leaflets produced by the British Association of Dermatology. We saw an advice leaflet on venous leg ulcers, which included information for patients on self-help.

Staff were able to give disease specific advice to patients such as foot care advice to patients with diabetes.

The Assisted Living Centre displayed leaflets in the reception area on a variety of topics, for example footwear advice and suppliers.

Complex case matrons provided instructions and medication to help patients manage their own exacerbations in their long-term conditions. This meant that patients could make their own decisions on the actions to take to promote their own health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their role and responsibility under the Mental Capacity Act 2005. The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. It applies to individuals over the age of 16. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLS).

Staff received training in MCA and DoLS. The overall trust compliance at April 2018 was 74%. The trust safeguarding lead told us that this training was delivered in conjunction with training for consent to treatment. Separate training was provided for ‘best interest’ assessors within the trust.

We saw documented in a patient’s records that staff had undertaken a capacity assessment for a patient in a residential home who was receiving care from the community nurse.

Some staff in the care networks had attended a day of dementia training and acted as a dementia champion for their teams. They had links with the dementia network in the acute hospitals.

We saw posters displayed on the wall in the care networks offices. The posters provided information for staff on the application of the Mental Capacity Act and best interest meetings.

We observed staff asking for patient consent prior to providing care and treatment. In the wound assessment clinic, staff asked patients for their consent to take and store a photograph of their wound on the electronic records system. We saw staff had documented patient consent in all 12 patient records we looked at.

Is the service caring?

Compassionate care

Staff treated patients with respect and maintained their dignity. We saw that staff had a good rapport with patients and relatives.
We observed a nurse providing excellent care when visiting a patient’s home to verify an expected death. The nurse was professional, compassionate and paid attention to detail in their duties. The patient’s relatives told us they were very grateful and appreciative of the care provided.

We spoke with 22 patients and relatives, who all told us they were happy with the care they had received and that staff were kind.

There was positive feedback from the friends and family test. The Community and Therapy Services Division scored between 95.7% and 100% during the period April 2017 to March 2018. They achieved a score of 100% for five of these 12 months.

**Emotional support**

Staff recognised the emotional needs of patients and relatives and were able to support these.

Staff were able to refer patients and carers to the psychology therapies or advise them on how to self-refer.

We observed a member of staff signposting a patient’s wife to the Carers Association for advice and support.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. We observed staff discussing the treatment plan with patients and involving them in setting individual goals.

The family of a patient we spoke with told us they felt supported and involved.

We saw evidence in care records that patients were involved in planning and making shared decisions about their care and treatment.

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**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

Equipment services had good relationship with the local commissioners and worked closely to plan services to meet the needs of patients.

We observed good interactions and working relationships between nursing staff and staff providing care for patients within residential care home settings.

Services were provided at multiple clinic sites across the patch to ensure they were easily accessible for patients. The Ironstone Centre provided several clinical services and was located centrally within the town of Scunthorpe next to a large car park and with good transport links.

Arrangements were in place to access interpreters and staff told us that this service was easy to access if required.

**Meeting the needs of people in vulnerable circumstances**

We saw that reasonable adjustments were made for vulnerable patients attending the wound care clinic. The service provided wound care to patients who had chaotic lives including the
homeless and those with an alcohol dependency. These patients often arrived late for their appointment and staff ensured that they were still attended to. If they failed to attend an appointment, staff tried to contact them to arrange another appointment to keep them engaged with the service.

The Assisted Living Centre had shower rooms with disabled access and a hoist. Patients were able to access these facilities during opening hours. Staff told us the bathroom door was not wide enough for bariatric wheelchairs and they had made a request to the commissioners to fund the alterations.

Staff in the care networks encouraged patients with learning difficulty to participate in their own care. We heard a telephone conversation between a nurse and a patient with learning difficulties. The patient had contacted staff to let them know they had successfully carried out the task. The patient was very proud of their achievement.

In order to meet the information and communication needs of people with a disability or sensory loss, the trust had developed a template on the electronic records system. The template captured information about people with specific health problems relating to how they access information. This included the patient’s requirements for communication support, the contact method, the information format and whether they required a communication professional, for example, a sign language interpreter. This information could be shared with other services, with the patient’s consent. However, staff we spoke with in community and therapy services were not aware of how to identify, record, highlight and share this information with others and were not able to give examples of when they had done this. Staff were not aware of the template on the electronic system.

**Access to the right care at the right time**

The community nurses working in the care networks teams provided care between the core hours of 7.30am and 7.15pm. They also provided an evening service between 6.15pm and 10.15pm and out of hours nursing between 9pm and 7.30pm (one band 6 nurse and one health care assistant). Staff handed patients over verbally to staff coming on duty and patients requiring visits were booked into the electronic appointments system.

A team of complex care matrons worked closely with patients with a serious long-term condition or complex range of conditions to directly provide, plan and organise their care. They produce an agreed maintenance plan in collaboration with the patient, to manage episodes of deterioration in health and prevent unnecessary hospital admissions.

During the winter, when the acute hospitals were under pressure, staff from the unscheduled care team and single point of access were asked to work on the acute hospital wards whilst the complex case matrons covered their work. This had an impact on the complex care matron’s caseload and they were concerned that approximately 30 patients had attended the Accident and Emergency Department, which might have been avoided if they had been able to respond.

The unscheduled care team’s role was to assist patients to remain in their own home or care home, if safe to do so, during an episode of acute illness. The team provided a service 24 hours a day, seven days a week. However, due to staff vacancies, there were insufficient staff to operate the service and the night shift had been suspended. At the time of our inspection, the service had been reduced to operate from 7.15am to 9.15pm. The trust had created an agreed action plan with measures in place to mitigate any potential risk. This was monitored and processes where in place to report to all relevant stakeholders.

There were long waits for patients referred to the continence service. At the time of our inspection, there were approximately 230 new patients on the waiting list with a 6 month wait.
There were insufficient staff in the service to meet the demand and when the specialist continence nurse was on annual leave or sickness absence there was no service available. Managers were aware of this issue and had developed an action plan in conjunction with the specialist continence nurse. To ensure that risk to patients was minimised, all referrals were clinically triaged and prioritised. Actions included the development of a new referral form with all the clinical information required to establish appropriateness of referral and a clear referral criteria and flow chart for professionals.

There was a single point of access service (SPA) for North Lincolnshire based at Global House in Scunthorpe. The service received call from GPs, health and social care practitioners, ambulance personnel and care homes. Patients calling 111 could also be referred to the service. Staff told us patients also contact the SPA direct, although the service was not originally set up for this. The service hours were 8am to 12 midnight. Between these hours, calls were diverted to a SPA in Grimsby. Staff used a clinical decision support solution to assist them in making decisions about patient triage. Staff working in the service told us that referral criteria were not clear to GPs and they often received inappropriate referrals, which took time to deal with. They were not aware of any action to address the incorrect referrals from GPs. The response target for triage call back were one hour for emergency, two hours for urgent and four hours less urgent. Staff told us that when demand was high they were not able to meet these targets.

The Early Stroke Discharge team based at Diana Princess of Wales Hospital told us they were not always able to meet the Royal College of Physicians stroke guidelines in both timeliness and intensity of treatment due to insufficient staffing levels. In addition, there were long waits for community neuro therapy (five months) and community rehab medicine (six months) in North East Lincolnshire.

Therapy staff working in the care networks told us they were not able to meet their targets of seeing urgent referrals within five days and routine referrals within four weeks. One therapist told us there were 73 referrals on the waiting list for therapy input and this included urgent referrals that had waited three weeks. We were told this was due to staffing vacancies and sickness.

We observed several clinics at the Ironstone Centre including podiatry, physiotherapy and wound care. These were all running to time.

Patients were able to self-refer or drop-in to the Assisted Living Centre (ALC). The centre was open from 8am to 6pm Monday to Friday and 10am to 4pm on weekends and bank holidays. The wheelchair service based at the ALC was able to respond to requests for emergency repairs within four hours. We saw in the performance report that the service was meeting the target for responding within four hours.

**Accessibility**

The largest ethnic minority group within the trust catchment area is White: Other white with 2.5% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White: Other white</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian/Asian British: Bangladesh</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian/Asian British: Indian</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>White: Irish</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accessibility tab)
**Referrals**

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The trust met the referral to assessment target in all of the targets listed.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Name of inpatient ward or unit</th>
<th>Please state service type</th>
<th>Days from referral to initial assessment</th>
<th>Days from initial assessment to onset of treatment</th>
<th>Comments, clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Target Actual (median)</td>
<td>Target Actual (median)</td>
<td></td>
</tr>
<tr>
<td>SGH Inpatient Therapies Acute assessment</td>
<td>within 24 hours or next working day</td>
<td>24h 24h 24h</td>
<td>Patients are seen as soon possible. Staff will regularly assess following referral-usually later in the day,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DPOW Inpatient Therapies Acute assessment</td>
<td>As above</td>
<td>24h 24h 24h</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDH Inpatient Therapies Acute assessment</td>
<td>As above</td>
<td>18 days. Urgent 1 day if required</td>
<td>18 days. Urgent 1 day if required</td>
<td>treatment initiates at assessment</td>
<td></td>
</tr>
<tr>
<td>Community Adult Therapies assessment</td>
<td>7 days urgent, 28 routine</td>
<td>18 days. Urgent 1 day if required</td>
<td>18 days. Urgent 1 day if required</td>
<td>treatment initiates at assessment</td>
<td></td>
</tr>
<tr>
<td>Community Adult Therapies speech therapy NEL</td>
<td>4 weeks 3 weeks</td>
<td></td>
<td>treatment initiates at assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Adult Therapies Speech therapy NL</td>
<td>4 weeks 2 weeks</td>
<td></td>
<td>treatment initiates at assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Adult Therapies Dietetics NEL</td>
<td>4 weeks 2 weeks</td>
<td></td>
<td>treatment initiates at assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Adult Therapies Dietetics nL</td>
<td>4 weeks 2 weeks</td>
<td></td>
<td>treatment initiates at assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Adult Therapies Wheelchairs</td>
<td>4 weeks 3 weeks</td>
<td></td>
<td>treatment initiates at assessment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Learning from complaints and concerns

We saw that information was available to let patients know how to complain.

Staff told us they tried to address patient concerns and complaints as early as possible.

Nursing staff were not aware of any relevant complaints and action needed to make improvements. We did not see any discussion on complaints within the minutes of the team meetings we reviewed. There was a new template for team meetings and complaints were not a standing item on the agenda.

Therapy staff told us they discussed complaints at team meetings. The community neuro team had recently participated in a development session on complaints led by a team leader who had an interest in this area.

Complaints

From March 2017 to February 2018, there were 10 complaints about community services for adults. The trust took an average of 31.6 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

A summary of complaints within community services for adults by subject below:

<table>
<thead>
<tr>
<th>Complaint subject</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>4</td>
</tr>
<tr>
<td>Appointments</td>
<td>2</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments
The trust received 277 compliments during the last 12 months from March 2017 to February 2018. Five of these related to community services for adults, which accounted for 2% of all compliments received by the trust as a whole.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Community health services for adults was part of the Community and Therapy Services Division. An associate chief operating officer, a divisional clinical director, an associate chief nurse and a head of therapies led the division. There had been some changes to the team since our last inspection. The associate chief operating officer remained the same and the divisional clinical director was in a leadership post but had a different title. The head of therapies was new in post and the associate chief nurse post was vacant and being recruited to at the time of our visit.

There were three care networks in North Lincolnshire. Each care network was managed and led by a team leader (Band 7) and an operational matron (Band 8a). There was also an operational matron for urgent care. The operational matrons reported to the deputy associate chief nurse.

Therapy staff provided services within acute and community settings and across North Lincolnshire and North East Lincolnshire. There was a separate management structure for therapy services. Three service leads reported to the Head of Therapies. Underneath the service leads were four operational leads for cross-site services. Team leaders reported to operation lead.

Although we found positive local leadership in some teams, there had been many changes in leadership at all levels through the division which offered little stability or continuity to teams. Most of the managers we spoke with were in interim posts or had been in post less than six months. Some managers were inexperienced and required support and training to develop into their new role.

There was a ‘Leadership and Management Development Competency Framework’ in place for staff moving into a management post.

Therapy staff we spoke with said they did not often see the middle or senior managers but felt supported by their local team leaders.

Nurse team leaders told us they had one to one meetings with line managers and felt well supported but did not see the managers above this level in the division.

However, we did receive good feedback from staff about the new chief executive and the chief nurse. Staff told us they felt they were listening and acting on what staff told them.

We heard from one team that staff had left due to the bullying behaviour of a manager and there were more staff planning to leave.

Vision and strategy

At the previous inspection, we reported that community teams should continue to develop strategies and a vision for their services. At this inspection, we did not find a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care.
There was no evidence of a structured planning process in collaboration with staff, people who use services, and external partners to develop a vision, values and strategy for this service.

Staff we spoke with did not have a good knowledge of the trust strategy and did not know if there was a strategy for community and therapy services.

Although there was no long-term strategy for the division, the divisional clinical director had developed a one-year plan, which he planned to share with all staff in the division. The plan had been written to reflect the shift in vision around culture, the new chief executive’s management style and took account of the staff survey results. We reviewed the plan and saw it set out aspirations for culture, quality, access and flow and sustainability across the division.

For some services within the division, there was no clear service specification and there was no framework around contracts. For example, the care networks service specification was in draft form and had not been agreed with commissioners.

Culture

We found morale varied across the division, but overall it was low in most services we visited. There had been a recent restructure in therapy services, which had led to some staff being downgraded and this contributed to low morale in some staff.

There was still a feeling amongst staff that the acute hospital side of the trust did not value them. Some staff said they felt bullied by senior managers into working in the acute hospital over the winter period and that the demands on community services were not recognised.

Despite low morale, we found staff were proud of their services and the care they provided to patients.

The mechanisms for providing all staff at every level with the development they needed were not in place. Staff appraisal rates were low and some staff felt their development needs had not been listened to or addressed.

We found processes were in place to keep lone workers safe. Staff were given mobile phones and lone worker devices with a panic button, which connected to a call centre. Staff recorded all visits on the ledger on the electronic records system. This allowed staff to show when they had completed a visit and were on their way home. Staff visited patients’ homes in pairs if a risk had been identified or staff visited after dark. Staff assured us they would walk away if they felt unsafe in a situation.

Staff felt the culture was improving in some ways and that it was moving towards a no blame culture. They were encouraged to report incidents and most staff felt able to raise concerns.

There was a high level of sickness in the division, over 20% in one team.

Governance

There was a clear governance structure for the division of community and therapy services. Divisional clinical governance meetings were held monthly, with a structured agenda including incidents, complaints, compliance with appraisals and mandatory training, risks, policies and items for escalation to the Quality and Safety Committee.

A central team of specialist staff supported each division with a risk and governance facilitator aligned to each division.
There were a range of senior management team meetings, which had a set agenda and included items for escalation. It was unclear how effectively managers cascaded information down from these meetings to operational staff.

Staff on the ground were clear on how to escalate issues through the management structure, however they did not feel the information was cascaded back down. We did not find learning from complaints and incidents was shared with front line staff.

There was a lack of oversight in some areas, for example, the governance framework around non-medical prescribing.

We found variation in local team meetings both in regularity and in content. Staff told us meetings did not always take place due to work pressures especially over the winter period.

**Management of risk, issues and performance**

Risks for community adults were held on an overarching divisional risk register. There were no local risk registers for community health services for adults. The divisional risk register included the risks identified to us by staff during the inspection however; we saw that many risks had been added to the register just prior to our inspection despite the issues being long standing. This meant the actions to mitigate and manage the risk were not timely or effective.

Staff were aware of the process to escalate risks, however they said the register was not shared with them and they were not clear on the actions taken to mitigate risks.

Performance was discussed at the senior management team meetings. The management team received a monthly community and therapies divisional performance report, which contained limited information on performance. The unscheduled care team and the single point of access had key performance indicators to meet and submitted monthly data to commissioners.

Staff in the care networks were able to describe what actions to take as part of the winter business continuity plans to ensure that older people and people in vulnerable circumstances continued to receive safe care. We saw that the service had business continuity plans for all teams, which prioritised essential services.

There was some evidence of internal audit to monitor quality of services but this was limited.

**Information management**

The wound care service was using a new template on the electronic records system to ensure every person with a lower leg wound had a full assessment. This was part of a Commissioning for Quality and Innovation (CQUIN) scheme for 2017 – 2019, which aimed to increase the number of full wound assessments for wounds that have failed to heal after four weeks.

Team leaders and staff working in the community development team were not assured that information supplied by the trust training department was accurate and up to date. The development team were planning to design their own method of collecting this data to ensure they had an accurate picture of what training individual staff had completed and what was outstanding.

Confidential patient information was kept securely on an electronic records system; however, on one occasion we saw paper records and a laptop containing patient information left in an unlocked room in residential care home. We also found some paper sheets containing patient information in a health premises car park. This was handed into the manager who took immediate action to report this incident and put measures in place to prevent a re-occurrence.
Engagement

We saw examples of positive working with external partners to provide services to the local population. There was good collaborative working in the care network with social care workers from the local authority. The service also worked closely with the local mental health trust and ambulance service to design and provide services in the community.

The trust had held a programme of listening events for the public at several locations around the patch. The event also provided a range of health market stalls and the opportunity for health checks for the public.

The service participated in the Friends and Family Test. The community equipment service had developed their own customer satisfaction survey to collect information from service users. The manager told us they used this information to improve the services they provided.

We did not find evidence of managers engaging staff so that their views were reflected in the planning and delivery of services and in shaping the culture. The staff survey results demonstrated this and managers were aware it was something they needed to do better.

Staff we spoke with said they still felt there was a lack of engagement with the acute hospital side of the trust. They received a monthly newsletter however; they said it was focused on acute hospital issues with little attention given to community services.

Learning, continuous improvement and innovation

The Division of Community and Therapy Services had a dedicated clinical development team who were responsible for delivering training and development across all professions. The team had developed a programme of education and improvement projects, which they monitored quarterly.

Staff were able to attend a quality service improvement and redesign course. One member of staff told us about a project to improve communication in the team by implementing a message of the week board, which contained key messages for staff.

The lead nurse for tissue viability had recently (April 2018) been appointed to a temporary post of quality lead for pressure ulcer prevention. The quality lead was working with the improvement academy to reduce the number of pressure ulcers in community and was working with other providers locally and nationally to share best practice.
Community dental services

Facts and data about this service

The Community Dental Service, integrated with the trust, operates from four community venues, Scunthorpe General Hospital and Diana Princess of Wales Hospital.

The service accepts referrals from a range of partners providing active prevention; restorative treatment; periodontal and prosthetic care; minor surgery; including the extraction of teeth; treatment under sedation and general anaesthetic (GA) as appropriate; orthodontics in liaison with the surgical division; pain & anxiety management services to local needs and agreed priorities.

A service priority is the provision of oral health care to disadvantaged groups who cannot or do not use the General Dental Services (GDS): children with extensive disease, from families who do not normally use the GDS and adults and children who are disabled and/or have a compromising medical problem affecting their oral health and accessibility to dental services. The service provides domiciliary care to those who meet the criteria. The trust is the provider of treatment not generally available in the GDS.

Other key objectives of the service include Oral Health Promotion: programmes and activities are provided within the general aims set out in the Oral Health Strategy and the specific aims as expressed in the Oral Health Promotion section & epidemiological studies investigating the patterns of oral diseases in the local community. The Community Dental Service (CDS) provides both a dental public health and treatment service acting in a complementary way to the hospital and general dental practitioners to meet the needs of the population of Northern Lincolnshire.

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training and their overall training compliance was 96% against this target.

A breakdown of compliance for mandatory courses as of October 2017 for medical/dental and other qualified staff (scientific, therapeutic, technicians) in community dental services is shown below:

Medical staff:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control - 1 Year</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Medical and dental staff achieved the target in nine of the 10 mandatory training courses. The only course that wasn’t met was for resuscitation which only one more staff member needed to complete it for 100% completion.

Other qualified scientific, therapeutic, technician staff:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Other qualified scientific, therapeutic, technician staff achieved the target in nine of the 10 mandatory training courses. Resuscitation was the only course that had not achieved the 85% target as there were two members of staff still to complete it.

Source: (Routine Provider Information Request (RPIR) – Training tab)

Mandatory training for staff included immediate life support (ILS), safeguarding children level one, two and three, safeguarding adults level one, information governance, mental capacity act and infection control. Training was a mix of online training and study days. Staff told us they had good access to training and were provided with protected time to complete the training. However, we were told that the computers at the locations were slow which made completing online training difficult.

Staff were encouraged to complete mandatory and this was actively monitored by the dental services manager. The dental services manager showed us the process for monitoring staff training. We were told that staff received an e-mail four months prior to when the training was required. This was then followed up with another reminder when it was due. We saw evidence of this system.

Updated records of mandatory training showed that mandatory training for community dental services was 94%.

Safeguarding

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training and their overall training
compliance was 95% against this target.

A breakdown of compliance for safeguarding courses as of October 2017 for medical/dental and other qualified staff (scientific, therapeutic, technicians) in community dental services is shown below:

**Medical staff:**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>5</td>
<td>6</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The target was achieved in three of the four safeguarding modules, and only one member of staff had not completed the Safeguarding Adults Level 1 module.

**Other qualified scientific, therapeutic, technician staff:**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Staff trained (YTD)</th>
<th>Eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The target was achieved in three of the four safeguarding modules, and only two members of staff had not completed the Safeguarding Adults Level 1 module.

A safeguarding policy was readily available on the trust’s intranet. The trust had a dedicated safeguarding team. Contact details were easily available for staff. These were both for the trust safeguarding team and the local safeguarding board.

As part of the mandatory training all staff are required to complete safeguarding children levels one, two and three and safeguarding adults. The service also got the trust safeguarding team in every year to provide in-house training about current issues with regards to safeguarding.

Staff were knowledgeable about the signs and symptoms of abuse. We were told that in the most recent training session they had been made aware of modern day slavery, human trafficking, radicalisation and Female Genital Mutilation (FGM).

Staff described to us the process for reporting safeguarding concerns. This included seeking advice form the trust safeguarding team and then escalating to the local safeguarding board if appropriate. We were shown examples of safeguarding referrals which had been made and these were in line with the safeguarding policy.

A process was in place to highlight patients who were subject to a child protection plan.

The service had a process in place for children who were not brought to appointments. This
would include notifying the parents or carers, the referring practitioner and the health visitor.

It was clear the service worked closely with health visitors and other healthcare professionals in the best interest of children and vulnerable adults.

**Cleanliness, infection control and hygiene**

Local decontamination was carried out for the reprocessing of contaminated dental instruments and equipment at all clinics which we visited. The clinics were meeting best practice Health Technical Memorandum (HTM) 01 05 (guidelines for decontamination and infection control in primary dental care) for infection control. Best practice HTM 01 05 was met because the decontamination units at each site we inspected had a separate room for processing contaminated dental instruments, an automated washer disinfector for pre-sterilisation cleaning and separate room for storing the processed instruments.

Storage of sterilised instruments was not always in line with guidance in HTM 01 05. We noted that re-usable dental burs were not bagged, kept in the surgeries and were not re-sterilised after 24 hours. HTM 01 05 states that any re-usable instruments should either be bagged and used within 12 months or if kept in the surgery un-bagged then they should be re-sterilised after 24 hours.

Staff described to us the end to end procedure for the processing of used instruments and equipment through the on-site decontamination rooms. Improvements could be made to the process. These include the lack of temperature monitoring of the solution used for manually scrubbing used instruments at all clinics, the lack of long handled brushes for manual scrubbing instruments at Cromwell Road and the Ironstone Centre and the lack of evidence to support the weekly changing of brushes and heavy-duty gloves at all clinics.

We observed the daily, weekly and three-monthly checks were carried out on the equipment used for the decontamination and sterilisation of used instruments. These were consistent with guidance in HTM 01 05.

Infection prevention and control audits were carried out every six months as described in the Health Technical Memorandum HTM 01 05. However, these audits had not identified the issues which we found during the inspection.

Hand washing facilities and alcohol hand gel were available throughout the clinic areas. Personal protective equipment (PPE) such as gloves and masks were readily available throughout the clinics. We observed staff followed the “arms bare below the elbow” guidance. The patients we spoke with confirmed staff wore PPE and they were provided with safety goggles and a protective bib.

We saw that there were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps. Safer sharps use was in accordance with the European Directive for the safer use of sharps.

Processes were in place to reduce the risks associated with Legionella. These included the regular flushing of the dental unit water lines and the use of a water conditioning agent.

We saw cleaning schedules for the clinics. The clinics were clean and tidy when we inspected them. The patients we spoke with confirmed this was usual.

**Environment and equipment**

The premises and environment at each clinic appeared clean and hygienic. However, at the
Ironstone Centre there was an unpleasant odour in one of the surgeries. Staff told us that this had been an on-going issue and had been raised with the facilities team. Nothing had been done to address this issue.

There was sufficient equipment at each location to ensure the safe and effective treatment of patients. These included dental hand pieces and other dental instruments.

There were equipment and medicines at each location for dealing with medical emergencies. These also included medical emergency kits for taking on domiciliary visits. This included an automated external defibrillator (AED), emergency medicines and oxygen.

We looked at the contents of the medical emergency kits and these did not reflect guidance from the Resuscitation Council UK. For example, at Cromwell Road there was no size 0 oro-pharyngeal airway, no child sized self-inflating bag and no size 0, 3 and 4 masks for the self-inflating bag. At the Ironstone Centre there was no size 0, 2 and 3 masks for the self-inflating bag. At Ashby Clinic there was no size 3 and 4 masks for the self-inflating bag. At St Hugh’s Avenue there was no portable suction and no size 0 mask for the self-inflating bag. We noted at all locations the AED pads had expired. These had expired in September 2016 (Cromwell Road and St Hugh’s Avenue) and July 2014 (Ironstone Centre and Ashby Clinic). We raised the issue of out of date AED pads on the first day of the inspection at Cromwell Road. Staff were unable to source replacement pads for the other locations as the trust did not stock replacement pads for these AEDs.

In addition, at Cromwell Road the oxygen cylinder in the domiciliary kit had passed its date at which it should be serviced (10 April 2018). At Cromwell Road the back-up adrenaline had expired on 31 March 2018 and in one of the surgeries the dispersible aspirin had expired in March 2018. We were told by staff and saw that weekly and monthly checks were carried out on the emergency equipment and medicines. These checks had not identified the issues which we found during the inspection.

We reviewed evidence of servicing and maintenance of equipment at all locations. Equipment involved in the decontamination and sterilisation of dental instruments had been serviced and maintained appropriately. However, we noted a wheelchair tipper at Cromwell Road was due to be serviced in April 2018. We asked the dental services manager if this had been done. They were not able to demonstrate this had been serviced. We were later told the engineering team had ordered the testing pack in order to service the wheelchair tipper.

We saw the service maintained comprehensive records in relation to dental X-ray equipment. A radiation protection advisor and supervisor had been appointed. Local rules were available for each X-ray machine. The dental service ensured the X-ray equipment was serviced and critically examined in accordance with the ionising radiation regulations (IRR 2017). We saw evidence that the dentists justified, reported on and quality assured X-rays when they were taken. This ensured that the service was acting in accordance with the Ionising Radiation (Medical Exposure) regulations IR(ME)R and protected staff and patients from receiving unnecessary exposure to radiation. The service had access to a radiation protection advisor (RPA) in line with IRR99 regulations. The RPA was able to provide advice and assist with risk assessments. The contact details for the RPA were in policies and protocols and on display in diagnostic areas.

Assessing and responding to patient risk

Throughout our inspection, we looked at examples of dental treatment records at each location. We found that dental staff always recorded patient safety alerts. For example, medical histories were always taken by dentists and updated when patients attended for dental treatment. These medical histories included any allergies and reactions to medication such as antibiotics.

Staff ensured that patients and carers received appropriate pre and post-operative instructions.
about treatments. This minimised the risk of the patient suffering from post-operative complications such as post extraction haemorrhage or infections. Information leaflets were given to patients and chaperones with details about what to do after having treatment under conscious sedation.

Staff we spoke with were aware of the process to follow if a patient became acutely unwell in dental services and required transfer to an emergency facility. If a patient required emergency resuscitation, this would be carried out by a trained member of staff, an ambulance would be contacted and the patient to hospital if required.

There were processes in place in to assess risks to patients and to monitor and maintain patients’ safety. Staff we spoke with were aware of the process to follow if a patient became acutely unwell in dental services and required transfer to an emergency facility. The trust also had a policy relating to the treatment of a patient attending with sepsis.

The service operated a minimal lifting policy. This means that patients are only ever lifted by staff in an emergency. In the event of a patient not being able to get out of a wheelchair then a wheelchair tipper would be used.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

Mercury and blood spillage kits were readily available at all locations which we visited.

The service had a process for receiving national patient safety alerts such as those issued by the Medicines and Healthcare Products Regulatory Agency (MHRA). Where relevant, these alerts were shared with all members of staff at staff meetings.

### Staffing

**Planned vs actual**

The trust reported their registered nursing staff numbers as below as at January 2018 and January 2017.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Planned WTE (Jan-18)</th>
<th>Actual WTE (Jan-18)</th>
<th>Planned WTE (Jan-17)</th>
<th>Actual WTE (Jan-17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Dental Team</td>
<td>3.0</td>
<td>2.9</td>
<td>2.9</td>
<td>2.9</td>
</tr>
</tbody>
</table>

The data did not include nursing staff at Diana, Princess of Wales Hospital or at Scunthorpe General Hospital. This will need to be requested from the trust and this section will be updated when the information is provided.

*(Source: Routine Provider Information Request (RPIR) – staffing tab)*

### Vacancies

From February 2017 to January 2018, the trust reported a vacancy rate of 0.6% in community dental services, which is lower than the overall trust target vacancy rate of 6.28%.

*(Source: Routine Provider Information Request – Vacancies tab)*

### Turnover
The data provided by the trust did not include any nursing staff for this core service. This will need to be requested from the trust and this section will be updated when the information is provided.

(Source: Routine Provider Information Request – Turnover tab)

Sickness

The data provided by the trust did not include any nursing staff for this core service. This will need to be requested from the trust and this section will be updated when the information is provided.

(Source: Routine Provider Information Request – Sickness tab)

Medical Staff

Planned vs actual

Staffing data provided by the trust did not include medical staff for this core service. This will need to be requested from the trust and this section will be updated when the information is provided.

(Source: Routine Provider Information Request (RPIR) – staffing tab)

Vacancies

Annual vacancy rates for medical and dental staff in the Community Dental Team from February 2017 to January 2018 are shown below, by site.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana Princess of Wales Hospital</td>
<td>0</td>
<td>43.2</td>
<td>0%</td>
</tr>
<tr>
<td>Scunthorpe General Hospital</td>
<td>3</td>
<td>33.6</td>
<td>8.9%</td>
</tr>
<tr>
<td>Community Dental Team total</td>
<td>3</td>
<td>77.8</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

From February 2017 to January 2018, the trust reported a vacancy rate of 1.8% in this core service, which is lower than the overall trust target vacancy rate of 6.28%.

(Source: Routine Provider Information Request – Vacancies tab)

Turnover

From to February 2017 to January 2018, the trust reported a turnover rate of 9.4% in this core service, which is the same as the overall trust target of 9.4%

(Source: Routine Provider Information Request – Turnover tab)

Sickness

From to February 2017 to January 2018, the trust reported a sickness rate of 2.3% in this core service, which is lower than trusts aspirational level of 4.1%.

(Source: Routine Provider Information Request – Sickness tab)
We were told that the service was fully staffed. However, staff raised concerns with us about the lack of administrative staff at each location. We were told and noted that reception staff were not available at each location. The services operated a system whereby patients would ring a bell when they arrived for an appointment. A member of staff would then come to greet them and advise them to wait in the waiting area. At one location we visited we rang the bell and had to wait approximately 10 to 15 minutes before a member of staff was able to attend to us.

Staff told us they felt stretched as they had to answer phone calls, listen to answerphone messages, file dental care records, and deal with patients at the reception area in addition to carrying out their other role. We witnessed this occurring at some of the clinics we visited. It was clear to us that even though we were told the service was fully staffed there were insufficient numbers of administrative staff to deal with patients arriving for appointments, requiring booking additional appointments and taking any payments.

We were told that the service rarely used bank or agency staff. Clinicians were requested to give reasonable notice prior to taking annual leave. This enabled the dental service manager to ensure there was sufficient cover from other locations to ensure patients could be seen in the event of a dental emergency.

Appropriately trained dental nurses supported the dentists carrying out sedation. All staff had completed immediate life support training.

The appointment diaries at each location we visited showed that sufficient time was booked for patient assessment and treatments. Staff confirmed they had sufficient time to treat patients safely and effectively.

**Quality of records**

Patient records were a mix of computerised and paper records. Audits of dental care records were carried out and results were discussed with the clinicians in order to disseminate learning. The results of the latest audits demonstrated that record keeping was generally of a good standard. Where issues had been identified an action plan had been formulated and this was discussed with clinicians. A repeat audit was planned to check on the improvements.

The 10 dental care records which we observed were well-maintained and provided comprehensive information about the individual needs of patients. These included an up to date medical history, details of the oral examination, consent and treatment plans (including an estimate where appropriate).

Clinical records were held securely to ensure confidential information was properly protected. Paper records were held in locked cabinets not accessible to the public. Computerised records were password protected and staff locked their computers when they were left unattended.

When a domiciliary visit was carried out the records were recorded on paper. Once the clinician had returned from the visit a summary of the visit was recorded on the electronic computer system.

**Medicines**

Medicines used in the provision of conscious sedation were stored in locked wall mounted metal cabinets. A recording system was maintained for the use of midazolam. This included the amount used for each patient. This ensured the safety of this medicine.

Gasses used in the provision of inhalation sedation were stored safely and in line with the manufacturer’s guidance.
Medicines which required refrigeration were stored in medical fridges and the temperature was monitored to ensure the cold chain was not broken.

When oxygen cylinders were taken on domiciliary visits appropriate signage was placed in the car and suitable insurance had been taken out.

Staff were aware of antibiotic stewardship and were familiar with current guidelines surrounding the prescribing of antibiotics. We were told that the majority of prescriptions which were made were for high fluoride toothpaste.

Prescription pads were stored securely at all times. However, a system for monitoring each individual prescription was not in place.

Safety performance

There had not been any never events at the community dental services in the previous 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. An example of a never event in dentistry is a wrong tooth extraction.

Staff were familiar with what would constitute a never event and were aware of the reporting process.

Incident reporting, learning and improvement

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community dental services which met the reporting criteria set by NHS England from March 2017 to February 2018.

(Source: Strategic Executive Information System (STEIS))

Since the previous inspection in October 2015 we were told that the staff awareness of significant event reporting had improved. Discussions with staff confirmed this.

Staff recorded significant events, incidents and accidents on the trust’s electronic reporting system. Staff demonstrated the use of this system. The dental services manager was responsible for investigating significant events. We looked at one particular significant event which had occurred and this had been well recorded and analysed. It was clear from the report that the patient had been fully informed of what had occurred in line with the requirements under the duty of candour.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person.

Is the service effective?

Evidence-based care and treatment
The dentists used national guidelines to ensure patients received the most appropriate care. This included the guidance produced by the British Society for Disability and Oral Health and the Faculty of General Dental Practice. Dentists we spoke with were knowledgeable about these guidelines and the standards that underpinned them.

The dentists providing conscious sedation were aware of the standards set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists ‘Standards for Conscious Sedation in the Provision of Dental Care’ 2015.

The dentists used rubber dam when carrying out root canal treatment in line with guidance from the British Endodontic Society.

**Nutrition and hydration**

Patients undergoing general anaesthesia were given appropriate information by staff of the need to fast before undergoing their procedure. The patient, parent or carer was given verbal and written advice about the need to fast prior to the general anaesthetic. The advice sheet was also available on the trusts website.

Patients undergoing conscious sedation were advised to have a light meal prior to their appointment. Again, the patient parent or carer was provided with verbal and written information with regards to this.

Staff told us and patients confirmed that advice about health diets was discussed during consultations.

**Pain relief**

The dentists assessed patients’ need for different levels of anaesthesia on an individual basis. For example, for very young patients when treatment under local anaesthesia was not possible a general anaesthetic was preferable.

In situations where patients were anxious about dental treatment, conscious sedation could be used. This took the form of inhalation sedation or intravenous sedation.

Local anaesthesia was used for the relief of pain during dental procedures such as fillings or extractions. We were told that topical anaesthetic was routinely used prior to administering a local anaesthetic.

**Patient outcomes**

The service carried out audits of dental care records, infection prevention control and conscious sedation. The clinical director was also in the process of completing an audit about the completion of the World Health Organization (WHO) safer surgical checklist. Results of audits were discussed with staff at meetings. No other clinical audits had been carried out.

In addition to audits the service had completed a patient satisfaction survey. Actions from this survey were to ensure patients were fully aware that unless they were exempt from NHS charges they would need to pay for treatment and to ensure patients were aware of the arrangements of whom to contact outside normal working hours. The survey results were all very positive in relation to the service being provided. In addition, patient feedback during the inspection was all positive.

**Competent staff**
Appraisal rates

From April 2017 to January 2018 86% of all staff in this core service had received an appraisal compared to a trust target of 95%.

A split by staff group can be seen below;

<table>
<thead>
<tr>
<th>Site</th>
<th>Staff Group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals completed (YTD)</th>
<th>Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>DPoW</td>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>4</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>7</td>
<td>6</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>SGH</td>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Other Qualified Scientific, Therapeutic, Technician Staff</td>
<td>3</td>
<td>2</td>
<td>67%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>22</td>
<td>19</td>
<td>86%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

Staff were encouraged to complete additional training relevant to their roles. This was to assist with the ever-increasing complexity of patients they were seeing.

All staff involved in the provision of conscious sedation had completed immediate life support techniques which was an appropriate level of training for a service that provided conscious sedation.

Several of the dentists had special interests. These included paediatrics, sedation, mobile dental services and epidemiology. The clinical director was on the General Dental Council’s specialist register for special care dentistry.

Peer review amongst the dentists occurred each quarter where dentists brought interesting clinical cases or cases where there had been particular difficulties in reaching optimum outcomes for patients.

Many dental nurses had completed extended duty training. These included radiography, special care dental nursing, conscious sedation, oral health education, fluoride application and impression taking. The dental nurses told us that they were able to use these skills within the service.

The service used a dental therapist to carry out some treatments. Dental therapists are qualified dental professionals who can carry out treatments such as fillings, extraction of deciduous teeth and periodontal treatment. We were told the dental therapist played an important part of the dental service.

As of January 2018, 86% of staff had received an appraisal. Most staff we spoke with said the appraisal process was worthwhile. We were told that performance was discussed at these
appraisals and a personal development plan (PDP) was drawn up.

**Multidisciplinary working and coordinated care pathways**

Multidisciplinary working was used throughout the service. Multidisciplinary team (MDT) meetings were held as part of best interest decision making or for patient with complex medical needs. We saw evidence of a multidisciplinary meeting between staff and the learning disability team.

Prior to special care patients undergoing a general anaesthetic, the dentist would liaise with the patient’s GP or consultant. This was to ensure any medical conditions were highlighted which could affect the safety of the provision of general anaesthetic.

The service maintained close relationships with local children’s centres, health visiting teams, learning disability teams and local mental health units. This ensured that vulnerable patients could access dental care in a timely manner.

**Health promotion**

Prevention was at the heart of the service. Staff were fully aware of the Department of Health’s ‘Delivering Better Oral Health’ toolkit (DBOH) when providing preventative advice and treatment to patients. DBOH is an evidence based tool kit used for the prevention of the common dental diseases. We saw evidence that oral hygiene advice, dietary advice and smoking cessation advice was given to patients. In addition, high fluoride toothpaste was prescribed to patients who were at high risk of tooth decay. Fluoride varnish was applied to patients’ teeth based on an assessment of the risk of tooth decay.

The service had a dedicated oral health promotion team. This team was heavily involved in visiting local schools, residential homes and children’s centres. They also provided tooth brushing kits to health visitors and nurses to give to parents with young children. One of the dental nurses who we spoke with told us that they had designed and produced a leaflet highlighting the importance of maintaining a healthy mouth. This leaflet had been distributed to local schools.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood the importance of obtaining and recording patients’ consent to treatment. The dentists told us they discussed treatment options and the associated risks and benefits of each treatment. We saw evidence of this in the dental care records we saw. Consent for treatment under sedation was obtained at a pre-assessment appointment following standards set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists ‘Standards for Conscious Sedation in the Provision of Dental Care’ 2015. This was then re-confirmed on the day of treatment.

Full and complete NHS consent forms (1, 2, 3 or 4) were used by each dentist each as appropriate in every case during the consent process. We saw evidence of completed NHS consent forms. Patients told us they felt involved in treatment decisions.

Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005. The dentists told us they carried out an assessment of a patient’s capacity and if the patient lacked capacity then a best interest decision would be made. Updated records showed that 91% of staff had completed Mental Capacity Act training.

Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.
Is the service caring?

Compassionate care

We observed staff treating patients with dignity and respect. Patients told us that staff were friendly, helpful and polite. We observed staff using language that was appropriate to patients’ age or level of understanding.

During one visit we witnessed a dentist arranging for music to be played for a nervous patient who enjoyed listening to music during treatment.

Privacy and confidentiality were maintained at all times. We observed that surgery doors were kept shut and when staff were dealing with patients at the reception area this was done discreetly.

Staff respected peoples’ individual preferences, habits, culture, faith and background.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. It was clear that staff adopted a holistic approach towards patient care. Staff listened to requests made by patients about how to ensure they were comfortable. We were provided with numerous examples of when staff “went the extra mile” to help patients receive treatment. This included singing to patients and holding their hands during treatment.

Appointment times and lengths were tailored to individual needs. For example, we were told that nervous patients would normally prefer wither early or late appointments. These were arranged and staff ensured these patients were not kept waiting. Staff told us that they had sufficient time to treat patients. We were told that they would often book acclimatisation visits where patients would be brought into the surgery to get accustomed to the environment.

Understanding and involvement of patients and those close to them

Patients and their families were appropriately involved in and central to making decisions about care options and the support needed. We saw evidence of information leaflets which outlined different treatments available at the service. We were also told that the dentists would often draw pictures to help patients better understand treatments. Staff also used models, X-rays and animations to help described treatments to patients. Staff also told us that they made an “awareness book” for some patients. This was a series of photographs of the dental environment. This book was sent to patients prior to their first appointment to help them become familiar with the setting prior to visiting.

Our observations of interactions between staff and patients confirmed that staff communicated with patients in a manner that helped them to understand their care and treatment. Patients and their parents commented that they were fully involved in the treatment decisions.

Is the service responsive?

Planning and delivering services which meet people’s needs

The dental service was commissioned by NHS England. Services were planned to meet the needs of people who could not access primary dental care services. These included patients with medical, physical or social issues and patients with dental anxiety.
Reasonable adjustments had been made to the premises to enable patients with medical or physical issues to access care. These included step-free access at all locations, automatic doors, fully accessible toilet facilities and wheelchair tippers. The wheelchair tippers could be used for bariatric patients if needed. The service had access to telephone interpreter services. Information leaflets were available in different languages if required. There was adequate parking at all clinics which we visited. There was also enough seating in the waiting areas at the clinics with the exception of the Ironstone Centre. The clinic shared a waiting area with the sexual health clinic. On certain days the sexual health clinic was particularly busy. This meant that seating in the small waiting area could be an issue. Staff confirmed this to be an issue. As the service had no control over this they were unable to make any changes. They told us they always tried to ensure their patients were not waiting too long for appointments.

All clinics were open Monday to Friday. Opening hours were displayed in information leaflets which were available on the trust’s website. Emergency appointments were available each day and we saw evidence that patients would be seen the same day if they were experiencing pain. Details of what to do in the event of a dental emergency were displayed in the waiting areas, in the information leaflet and on the answer machine. However, at the Ironstone Centre the service was unable to have the details of the out of hours emergency service as the answer machine service was managed by the owners of the premises.

**Meeting the needs of people in vulnerable circumstances**

The service was configured to reflect the needs of vulnerable people. The service was primarily a referral based specialised service providing continuing care to a group of patients with additional needs due to physical, mental, social and medical impairment. They also provided continuing care to children due to the lack of access to NHS dentistry in the area.

Staff visited special schools, mental health units and residential homes to provide oral hygiene advice. We were also given an example of when staff got involved in treating a homeless person. They would ensure the patient was seen as and when required and took into account their individual circumstances.

Domiciliary visits were carried out by the service. These visits were reserved for patients who could not access the service due to medical, physical or social issues.

**Access to the right care at the right time**

General dental practitioners and other health professionals could refer patients for short-term specialised treatment as well as long term continuing care to the community dental service.

Referrals were received into the service and initially triaged by a dental nurse. They were then passed onto a dentist to allocate the most appropriate clinic to be seen at. There was a system in place for referring dentists to highlight when a referral was more urgent.

The waiting time for an initial consultation at the community dental services was five weeks and ranged from three weeks to seven weeks.

There was currently a waiting time of seven weeks for a general anaesthetic for children and 17 weeks for a special care adult. We were told this waiting list for adult patients was because these patients usually required a whole session to be treated.

Internal referral systems were in place, should the dental service decide to refer a patient on to other external services such as local maxillofacial services. The service reported that there were no delays with internal referrals.
During the inspection we observed that appointments ran smoothly and patients were not kept waiting. Staff told us that patients would be kept informed if there were going to be any delays with their appointment.

**Learning from complaints and concerns**

The service had a low level of complaints. Two complaints had been received in the previous 12 months. The dental service manager dealt with complaints as and when they arose. We looked at the correspondence relating to these complaints and saw that they had been dealt with appropriately and in an open and transparent manner. We were told that learning from complaints was discussed at team meetings to disseminate learning and prevent future issues.

There were details of how patients could make a complaint displayed in the waiting area, in the patient information leaflet and the trust’s website.

**Is the service well-led?**

**Leadership**

The clinical director maintained overall responsibility and accountability for the running of the service. The dental services manager was responsible for the day to day running of the service. Several staff members had individual lead roles within the service such as safeguarding and infection prevention and control. This led to a culture of individual responsibility and accountability within the service. The clinical director and dental services manager were responsible for passing information between staff and senior managers. We were told there was open and regular contact between the dental services manager, clinical director and senior management. The clinical director had monthly meetings with the divisional clinical director to discuss the performance of the service.

Staff confirmed that they felt valued in their roles within the service and the local management team were approachable, supportive and visible.

**Vision and strategy**

The service had a formal written strategy in line with that laid out by the NHS commissioners. The vision of the service was to focus on the needs and help improve the oral health of the local demographic. It was clear that staff were committed to this vision by getting involved in local health care initiatives and also helping support vulnerable people by educating them and their carers in methods to improve their oral health. Staff told us the clinical director was forward thinking and provided support and encouragement in order to achieve the service’s vision.

The trust’s values were “together we care, we respect, we deliver”. These values formed part of staff appraisals.

**Culture**

Staff were proud and passionate about the work they did and it was clear they were dedicated to their individual roles. They continuously strived to provide high quality treatments in a caring and compassionate manner for their patients. They often went "above and beyond" to achieve this.

Morale at the service was good. The service was due to be re-tendered over the past few years, however, this had fallen through leading to a sense of un-certainty. However, the resilience within
the staff base ensured that the service continued to run unaffected and patients received high quality compassionate care.

Staff were aware of their responsibilities to raise concerns if the need arose. They were aware of the whistleblowing process and could easily access the policy. They were aware of the freedom to speak up guardian and could access their details on the trust's intranet.

Staff were aware of the need to be open and transparent with patients. We were given examples of when staff had applied with duty of candour in response to certain situations and circumstances.

**Governance**

The service had a set of policies and procedures which were regularly updated. These were readily available on a shared computer system. Staff were familiar with how to locate these policies. Policies included safeguarding children and vulnerable adults, infection prevention and control and radiation protection.

Whole service meetings were held every six months where all staff got together. In addition, informal morning huddles were held to discuss the upcoming day to identify any potential problems which would be anticipated. The dental services manager attended monthly governance meetings where complaints, mandatory training and significant events were discussed. The clinical director attended two-monthly departmental meetings where topics such as finance were discussed.

Effective systems and processes were not in place to ensure equipment and medical emergency equipment and medicines were properly maintained. We identified gaps in the medical emergency kits, out of date medicines, out of date AED pads, an out of date oxygen cylinder and a wheelchair tipper that had passed its service date. These issues had not been identified by the systems which were in place.

Some quality assurance processes were in place. For example, we saw audits of infection prevention and control and sedation. However, the last X-ray audit had been completed in 2015. IR(ME)R states that a system of regular audits is essential.

**Management of risk, issues and performance**

The service maintained a risk register which was reviewed by the dental service manager. This was used to monitor known risks associated with the service. We reviewed the current risk register and saw one entry associated to the service. This was related to the IT systems. Key risks which we identified during the inspection (equipment maintenance, premises issues and infection control issues) had not been identified on the risk register and assessed by the provider.

The divisional clinical director also described other risks associated with the service. These were the uncertainty with the tendering over the past years and the difficulty in getting the units of dental activity (UDAs).

**Information management**

Staff had completed training in information governance and were aware of the importance of protecting patients’ personal information.

Dental care records were a mix of computerised and paper records. We saw computers were password protected and were told these were backed up to secure storage. Any paper records were stored in lockable cabinets. We saw staff locked computers when they moved away from
their workstations.

Engagement

The clinical director had representation on the managed clinical network (MCN) for Special Care Dentistry. An aim of the MCN for Special Care Dentistry was to engage with local general dental practitioners so they could work alongside each other in the provision of shared care for patients with a variety of special needs. This was an opportunity to advertise the work which they did and encourage others to get involved in special care dentistry. This would enable general dental practitioners to treat patients with mild to moderate levels of special needs whilst having experienced clinicians from the service providing advice and expertise where necessary.

One of the dentists was the chair of the South Humber Local Dental Committee (LDC). This gave them an opportunity to engage with the local dentists and discuss any challenges which they had with regards to the community dental service. They were also able to discuss the epidemiological work which they were also undertaking.

Patients were encouraged to complete the NHS Friends and Family Test (FFT). This is a national programme to allow patients to provide feedback on NHS services they have used. We also observed many thank you cards which had been received from patients at all clinics which we visited.

Staff were able to engage with local management. They told us this could either be through the appraisal system or a more informal process with the dental service manager. Staff told us the local management were approachable and would listen to any concerns which they may have.

Learning, continuous improvement and innovation

Learning and continuous improvement was at the heart of the service. Many of the dental nurses had completed additional training in subjects such as dental radiography, conscious sedation, fluoride varnish applications and oral health promotion. Staff were encouraged to complete these additional courses and were able to use these skills within the service.

The service was currently working with Public Health England to carry out epidemiology surveys. This was to assess the dental health of the adult population of the local area.

The service was heavily involved in local initiatives to improve the oral health of the local population. These included the oral health promotion team visiting special schools, mental health units and residential homes to provide oral hygiene advice. They also provided oral hygiene advice to health visitors, nursery nurses and residential home staff. The team was also involved in the “brushing for life” campaign. This is a campaign which targets the provision of toothbrushes and toothpaste through health visitors.

One dental nurse had also designed and produced a leaflet highlighting the importance of maintaining a healthy mouth. This leaflet had been distributed to local schools. They also took part in national campaigns such as oral cancer month.
Community end of life care

Facts and data about this service

<table>
<thead>
<tr>
<th>Location site name</th>
<th>Team/ward/satellite name</th>
<th>Patient group</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hewson House</td>
<td>Macmillan Palliative Care Team</td>
<td>Mixed</td>
<td>24-hour service</td>
</tr>
<tr>
<td>Global House</td>
<td>Macmillan Health Care Team</td>
<td>Mixed</td>
<td>24-hour service</td>
</tr>
</tbody>
</table>

End of Life Networks

The trust has provided information about the networks it belongs to:

‘Through the End of Life Multi-Agency Strategy Group, we work with NLAG colleagues, St Andrews Hospice, Lindsey Lodge Hospice, Care Plus Group, RDASH, Lincs East Community, Skills for Care (NL CCG), North Yorkshire and Humber Clinical Networks Team Representatives and with CCG Continuing Care. We also work in conjunction with Hull and East Yorkshire regarding EOL care.

Communication and joint working has commenced with the local council regarding shared EOL training. Patients are referred into the service from acute care, GP, Macmillan nurses into the care networks via a fast-track system. Patients sit under the district nursing caseload but may also receive input from Macmillan Healthcare Team for personal care and both the Macmillan Therapy Team and Macmillan Nurses to provide the patient with a holistic care package for EOL’.

Community end of life care is delivered within the community by the MacMillan Specialist Nursing team, the MacMillan Healthcare team, the consultant for palliative care, the district nursing teams and the patients’ respective general practitioners.

The specialist palliative care team nurses are based at two locations within the community and are part of the Community and Therapy Services of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG).

Between the dates of April 2017 and March 2018 there were 436 patients identified whose place of death was not in hospital.

Our inspection was announced and staff knew we were coming to enable us to observe routine activity.

We spoke with ten patients and five relatives. We also spoke with 34 members of staff, including senior managers, the specialist palliative care team, nurses and allied health professionals.

We observed care and treatment and looked at 16 care records that were receiving either palliative or end of life care. We reviewed 10 do not attempt cardio pulmonary resuscitation forms.

Is the service safe?

Mandatory training

Mandatory training completion rates
The trust set a target of 85% for completion of mandatory training.

From February 2017 to January 2018 the breakdown of compliance for mandatory courses for different staffing groups is shown below:

Macmillan nursing staff:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
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<tr>
<td>Manual Handling - Object</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
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</table>

Support to doctors and nurses:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>31</td>
<td>31</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>29</td>
<td>31</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>29</td>
<td>31</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>29</td>
<td>31</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>PREVENT Level 1</td>
<td>28</td>
<td>31</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>28</td>
<td>31</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>27</td>
<td>31</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control - 1 Year</td>
<td>27</td>
<td>31</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>27</td>
<td>31</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>24</td>
<td>31</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

From February 2017 to January 2018 the breakdown of compliance for safeguarding courses by staffing group is shown below:
Macmillan nursing staff:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
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<tr>
<td>Safeguarding Children (Level 2)</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Support to nursing staff:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
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<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>25</td>
<td>31</td>
<td>81%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>23</td>
<td>31</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>23</td>
<td>31</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Staff we spoke to were aware of how to identify any safeguarding concerns and how to escalate these.

**Cleanliness, infection control and hygiene**

The syringe drivers were cleaned after each usage and held in a central storage area in one of the two community hubs.

All of the syringe drivers that we observed during our inspection appeared clean and all had “I am clean” stickers attached that were dated.

Staff undertaking community visits had adequate supplies of hand sanitiser and personal protective equipment such as disposable gloves and plastic aprons and we saw these items being used effectively during clinical procedures in people’s homes appropriately.

At one of the community bases we observed a notice board entitled ‘responsibility framework for care tasks in community care settings 2018’ upon which was listed all the equipment such as stethoscopes, sphygmomanometers (used to take blood pressure) and syringe drivers. Next to each it was listed which staff member was responsible for that piece of equipment, the cleaning schedule and information on how to clean them correctly.

**Environment and equipment**

There were centralised store rooms in each of the two community hubs which were not accessible to patients. These stores contained equipment that staff required to carry out their work, such as blood bottles and dressings. Within these locked rooms were locked drug safes that contained adrenaline vials in case of anaphylaxis.

Most of the equipment in these rooms that we checked was in date. However, at one site we found nine blood bottles used for taking blood samples to ascertain blood group and crossmatch
which were out of date by nine days. We escalated this to a staff member and they were removed immediately. We were assured that all staff members would check the expiry date of the bottles prior to using them.

The trust utilised portable syringe drivers, which were battery operated devices used for delivering precise amounts of continuous subcutaneous medications. All of these pumps were lockable to prevent any improper or accidental changes to the rates of infusion.

The team had a system in place that monitors where each syringe driver is and which patients those allocated to and their addresses of where they are. This system also ensured that they were sent for servicing when recommended. We were shown the folder that contains all of this information.

The service also had a supply of nebulisers, which are devices that helps the patient take medication by changing liquid medication into a fine mist, meaning that it can then be breathed in via a mouthpiece or mask. We saw three in the storeroom that were all clean, serviced and ready to be used with batteries supplied also.

There was an on call occupational therapist at weekends that would be able to assist staff and patients when requested and also provide additional equipment such as a commode. We did not observe any delays in patients receiving any equipment.

**Assessing and responding to patient risk**

We observed documentation, as part of the care in the last days of life document that the trust used, that risk assessments were carried out routinely in a variety of different aspects of care in all of the records that we reviewed. These included pressure area care and the ordering of subsequent equipment to minimise this occurrence, moving a handling and mouth care.

We observed continual evaluation of these risks and subsequently updated in the respective ‘care in the last days of life document’ when observing patient care in their own homes.

We observed an incident form being completed after a patient in the dying phase had developed a pressure sore.

**Staffing**

Staffing for end of life care was the responsibility of all staff in the community and not restricted to the palliative care team.

The district nurses were available 24 hours per day, seven days per week and managed the end of life patients as part of their general caseload with the specialist palliative care team reviewing and supporting complex patients.

The Macmillan healthcare team, which are employed by the trust, consists of 38 band two, three and four workers. They provide support for the patients such as visiting their homes to assist with personal cares. They also provide overnight sitting in patients’ homes to provide respite care to relatives and family members as well as clinical care to patients.

The service has only one consultant for palliative care who was usually based at the two hospital sites Monday, Wednesday, Thursday and Friday and was based at one of the community hubs on a Tuesday. However, we were told that this was flexible. However, the lead professional for patients who are being cared for in the community is the respective general practitioner.

**Vacancies**
Between February 2017 and March 2018, the trust reported an overall vacancy rate of 4.1% in community end of life care. This was below the trust’s target vacancy rate of 6.3%. The trust did not provide any information about staffing levels in community end of life services.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Nursing – Bank and Agency Qualified nurses**

The trust did not provide any details of bank or agency usage in community end of life care.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical locums**

The trust did not provide any details of locum usage in community end of life care.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Quality of records**

Patient records within the community setting were predominately on an electronic system. We were informed that approximately 90% of general practitioners in the area had access to this system which meant that all professionals involved in the care of patients were able to update records contemporaneously and view documentation that other carers had inputted immediately.

However, we were informed that the acute hospital electronic patient record system was not compatible, and with the exception of the accident and emergency team who did have access, the system in the rest of the hospital was not linked with the one in the community.

Staff each had a portable device to access the relevant records. However, most staff we observed did not take the mobile devices into patients’ homes as they were felt to be a barrier between communication so their documentation was duplicated.

There were limited paper records held in the respective patient’s homes, such as the do not attempt cardio pulmonary resuscitation (DNACPR) record which staff advised patients and their relatives to keep at the forefront of their hand-held notes. We observed these in situ in patients’ homes.

Do not attempt cardio pulmonary resuscitation was also documented on the community information technology system.

We viewed 16 sets of records, both paper-based and electronic, and they were all up to date and complete, with regular reviews by clinicians documented and risk assessments such as pressure sore development risk were completed.

**Medicines**

Community staff involved in the administration of controlled drugs were expected to carry adrenaline and the syringe and needles, to administer should a patient suffer an anaphylactic reaction as per the trust’s guidelines. To protect these vials from breaking we observed that one staff member had utilised an old spectacle case to contain this and the needles and syringe needed for administration.
These vials of adrenaline were stored securely in both of the two community hubs and each staff member was responsible for ensuring that the medication they carried for this purpose was within the usage date. These were all in date except one single vial at one site. This was highlighted to the senior sister at the site and it was disposed of immediately.

We were told that there was no formal process for checking the expiry dates of such medicines on a regular basis. However, following discovery of this one vial of expired medication a system of daily checking was implemented immediately.

All community staff had access to DOOP (Destruction of Old Pharmaceuticals) kits which are used in the process to safely dispose of unused medication such as unused syringe driver medication. If there is only one staff member present when disposing of medication, we were informed that the family countersign that it has been disposed of appropriately.

Staff had access to an anticipatory drug prescribing policy. These were medicines that it was anticipated that a patient nearing the end of their life may need to be prescribed. This policy outlined practice to ensure these medications are already in place in the respective patients’ home to be administered by the attending nurse or doctor immediately, thereby avoiding unnecessary delays to this treatment.

The trust had identified that some inpatients of North Lincolnshire and Goole NHS Foundation Trust hospitals were discharged into the care of a general practitioner who would not be able to prescribe this range of anticipatory medications immediately. Therefore, they amended their policy to state that all patients being discharged from their hospitals would take home five days’ supply of anticipatory medications to be used should they need it until their respective general practitioner could arrange an ongoing prescription.

There was currently one nurse prescriber in the Macmillan nurse team. However, we were told that another member of the team was due to commence this training in the near future.

We were shown evidence of a recent medication error whereby a patient had been given too much of a prescribed medication. The incident had been reported on the trust online incident reporting system and subsequently investigated. A member of our inspection team was present when a senior nurse complied with duty of candour recommendations and shared the lessons learnt from the incident.

**Incident reporting, learning and improvement**

**Serious Incidents - STEIS**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community services for end of life care, which met the reporting criteria, set by NHS England between March 2017 and February 2018.

The trust had an incident reporting policy for staff to follow. We observed in some staff areas that there were trigger lists of what incidents should be reported, but these were not visible in all areas.

Staff we spoke to were aware how to report incidents on the information technology system for this purpose. However, some staff did not appear to be aware of precisely what incidents to report.
Staff that we spoke understood and were able to explain duty of candour, which is a regulatory duty on healthcare providers to be transparent and open with a patient or relative when harm is done to them.

Following the inspection, the trust reported serious incident in January 2018 coded as end of life care. This incident arose after a patient had been discharged from a hospital general practitioner out of hours service to the community team without a specific form needed for the community team to administer the medication. The immediate action taken ensured that the patient received the medication as prescribed. The incident was investigated utilising a multidisciplinary approach. The action taken was an update to the administration chart and a draft updated policy to prevent this issue occurring again and the lesson learnt was to improve communication between all stakeholders.

Is the service effective?

Evidence-based care and treatment

The care and treatment, and the documentation used to record this, complied with the National Institute for Clinical Excellence (NICE) NG31: Care of dying adults in the last days of their life and Ambitions for palliative and end of life care: a national framework for local action 2015 – 2020.

In response to the ‘More Care Less Pathway’ report which was published in July 2013 the Liverpool Care Pathway was withdrawn the trust produced the Care in the Last Days of Life Document which is in two parts. We observed these documents being used appropriately when staff were caring for patients nearing the end of their lives.

The service was not working towards an independent accreditation standard such as the Gold Standard Framework, which is a programme that enables good quality care for people nearing the end of their live, irrespective of diagnosis, by planning care in line with their needs and preferences. This was an action for development in our last inspection in 2016.

However, the Macmillan specialist palliative care team demonstrated a good knowledge of this framework.

The NLAG End of Life Strategy Implementation Group Work Programme highlighted that funding had been obtained for the Macmillan nurses to train eight general practitioner practices in their catchment area for a period of one year in the ‘going for gold’ Gold Standard Framework work.

Nutrition and hydration

Patients nutrition and hydration needs were assessed initially and continually evaluated and documented on their care plan.

A ‘Coping with Dying’ leaflet was given to patients and those caring for them that highlighted what to expect when a patient is nearing the end of their life. This included the diminished need for food and drink and the possibility of the patient needing intravenous fluids at some point.

We observed discussions with both patients and relatives about nutrition, hydration and mouth care.

Pain relief

Patients who received end of life care within their own homes remained under the care of their respective general practitioner and the community end of life care team. The respective general practitioner were responsible for prescribing the end of life medication, including pain relief, in the period immediately following the five days of anticipatory medication.
All of the patient records we reviewed highlighted compliance with their anticipatory drug prescribing for end of life care guideline. All the records we reviewed had been prescribed pain relief and other medication that may be needed by the patient to avoid any delay in administration.

There was a comprehensive flowchart within the Care in the Last Days of Life Document – Part 1 that we observed that each end of life care patient had completed. This highlights clear guidance for health professionals of what pain relief medicines to administer and when.

The trust provides patients receiving opioid medicines for palliative care, which is a range of strong medication that is mainly only available by prescription, a leaflet explaining issues such as the different types of medication, possible side effects and safe storage in the home.

**Patient outcomes**

The specialist palliative care team shared monthly data of patients known to their service and their preferred place of death since June 2016. The average for each were home 85% (n = 268), hospice 80% (n = 121), nursing home 97% (n = 114) or hospital 100% (n = 61).

We were told that patients in hospital who choose to end their life can be transferred home within 24 hours with the fast track pathway.

The palliative care leadership team firmly believe that the key to keeping people at home who want to end their life there is due to the input of the Macmillan healthcare team.

Key performance indicators shared by the trust between the periods April 2017 and March 2018 highlighted that there were 436 patients identified whose place of death was not in hospital.

16.5% had care in the last days of life recorded. The trust was aware of this figure due to them re auditing this and had an action plan to address this specific issue. The community results were overall higher than those in the acute setting, when marked against compliance with the standards. However, their low areas included patients not being informed they were in the last days of their life, a lack of documentation that re-assessments had been carried out every three days, families being informed that death was imminent and a lack of evidence for care following death.

81.2% of patients had a preferred place of death recorded which is above the trusts target of 80%.

73.9% had an anticipatory medication package in place. However, 96.3% of patients had this package in place when under the care of the palliative care nursing team.

84.4% had a do not attempt cardio pulmonary resuscitation (DNACPR) in place. However, for those under the care of the palliative care nursing team this figure was 96.3%.

**Competent staff**

New starters to the Macmillan Healthcare Team receive a workbook as part of their comprehensive preceptorship package that they are required to complete alongside dedicated supernumerary practice whereby they were able to shadow another colleague already competent in the role.

We were told that all new starters to the community teams were given a similar comprehensive preceptorship package to enable them to become competent in their new role.

During our inspection there was an ongoing palliative care course for registered nurses and allied health professionals held one day a week for six weeks at a local hospice. The course content
included Principles of palliative care and Care in the last days of life documents, both presented by the trusts palliative care team.

**Clinical Supervision**

The Macmillan nurses stated that they received regular clinical supervision. Furthermore, that they had a supportive management team and that they could approach them at any time a one to one meeting.

The Macmillan nurse team stated that they offer clinical support to the district nursing team in caring for end of life patients.

The Macmillan team told us that they taught end of life care to both trained and untrained staff and to all new starters as part of their preceptorship programme.

The Macmillan Healthcare team told us that they received clinical supervision every three months and that there were plans in place to commence sessions on resilience and mindfulness training. One staff member told us that she wished there were more secondments to train as a nurse so that she could help patients more and that she was most proud of the care and compassion that she and the team could provide to patients and their loved ones.

**Appraisals**

From April 2017 to January 2018, 59% of staff within the community end of life care services core service had received an appraisal compared to the trust target of 95%.

<table>
<thead>
<tr>
<th>Reporting Unit</th>
<th>Staff Group</th>
<th>Individuals required (YTD)</th>
<th>Appraisals complete (YTD)</th>
<th>Actual Completion %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care</td>
<td>NHS Infrastructure Support Staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>Qualified nursing staff</td>
<td>8</td>
<td>5</td>
<td>63%</td>
</tr>
<tr>
<td>Macmillan Healthcare Team</td>
<td>Support to Doctors and Nursing Staff</td>
<td>31</td>
<td>17</td>
<td>55%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff we spoke with told us that they had had an appraisal and that they felt that their appraisals were meaningful and helped them a lot in their clinical practice and career.

**Multidisciplinary working and coordinated care pathways**

Members of the specialist palliative care team participated in multidisciplinary meetings in the trust which are held every Tuesday.

We were told that not all general practitioners were accredited for the Gold Standard Framework scheme. Of those that were, some held monthly meetings and some every three months. The Macmillan team attended and participated in all of these.

The palliative care team have worked with staff from local nursing homes resulting in the team being contactable by nursing home staff for advice and support in end of life care.

The community palliative care team work collaboratively with the hospital team to improve the patient experience.
There was multi-disciplinary and multi-agency working to facilitate the fast track process when care in the community was identified for patients at the end of their life. During our inspection we saw nursing and medical staff refer patients through this process. Furthermore, we saw documentation that general practitioners had done so also.

Health promotion

Patients with long term conditions were empowered and supported to monitor their own health, care and wellbeing and to take proactive

Staff informed us that patients on oxygen therapy received advice regarding smoking due to the risk of burns and fire.

New starters to the Macmillan Healthcare Team undergo a comprehensive preceptorship package which includes information regarding the ‘Making Every Contact Count Lifestyle Services’ that they are able to refer patients to. Services offered include stopping smoking, weight loss, reducing alcohol use and psychological therapies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The department reported no Deprivation of Liberty Safeguards (DoLS) made to the Local Authority in the year immediately prior to our inspection that were pertinent to end of life care in the community.

Staff were able to explain when patients may need an assessment of their capacity to make decisions about their care or when staff may need to make a decision in their best interests.

Staff told us that DNACPR audits, including the community environment, were carried out. We requested data and any action plans from these. However, we were not provided with this information.

Staff informed us that patients and those caring for them were advised to keep the DNACPR form at the front of their notes and in the notes we reviewed, they were. In one of the patients homes the notes could not be found by the relative and as such this form would not have been available if needed urgently. However, we observed that the decisions regarding DNA CPR were recorded on the information technology system of each patient and we observed staff reviewing each set of notes prior to attending each patient.

The DNACPR forms that we viewed during our inspection were completed either by a senior clinician or the general practitioner. Of the one where the patient lacked capacity, the decision had been made in the best interest of the patient and the guideline had been followed and the process had been documented appropriately.

During our visits to patients homes we observed DNACPR decisions being actively reviewed. Staff could access mandatory mental capacity act training, which was either classroom based or e-learning and was updated every three years. As of April 2018, we were informed that 91% of staff were in date with this training.

Is the service caring?

Compassionate care

During this inspection we saw examples of staff showing compassion and caring to patients and relatives in their care.
We saw the personalised cards sent to the bereaved relatives that had been cared for by the teams, from the Community Macmillan Nurse Specialists expressing their condolences, providing a contact number for their continued care and informing them of the future offer of bereavement care.

The one whole time equivalent Consultant for palliative care for the trust divided his time between the hospital and community and made time in his working day to facilitate home visits to patients.

During our inspection we were invited in to the homes of ten patients receiving end of life palliative care. We saw how staff interacted with these ten patients and the five relatives that were present. Staff were polite, courteous and consistently displayed genuine empathy to the patients and their families.

Most of the palliative care team attended the funeral of one of the patients they had been caring for and the family were heard to praise their ‘excellent service’ and ‘so caring’.

Both the Macmillan Healthcare team and some members of the district nursing team had received the Andree Borrett (an award set up by the trust in honour of a previous staff member who lost her life in 2010) award for going the extra mile and providing outstanding care to patients.

**Emotional support**

Staff told us that they would support every patient, their respective families and those close to them in any way they could, ensuring they received the time that they needed.

Bereavement support was offered to all relatives following their loss and they were able to signpost to external agencies should that be required.

The specialist palliative care team also made contact with loved ones of bereaved patients known to the service and sent them a sympathy card informing them of continued support.

We saw repeated instances where all staff gave the patient and their carers as much time as they need to either talk or reminisce about their memories with their loved one.

We were present when the Macmillan nurses were carrying out a follow up telephone calls to relatives following their partner’s bereavement. The nurses were heard to be empathetic, caring, asking and offering advice about such practicalities as the funeral arrangements and offering further home visits to ascertain if they were coping.

**Understanding and involvement of patients and those close to them**

During our inspection we observed numerous thank you cards and letters from relatives and close friends of people that the teams had cared for expressing gratitude for the care that had been received.

We were told by one relative that the team were extremely helpful when their partner had died, even the Macmillan administration team had written letters to the children’s universities to inform them that their Mother had died.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**
The 38 members of the Macmillan healthcare team provided care to people in their own homes from 8am until 9pm seven days per week.

There were also two members of the team on every night shift offering care to patients and a sitting service in the patients’ homes to enable the relatives to get some rest.

We observed a relative being told that the Macmillan healthcare team would visit up to four times per day when their loved one was nearing the end of their life.

Two of the palliative nursing team attended nursing and care homes in the area to carry out end of life care.

Patients could be admitted to a local hospice for day care to receive treatments such as complementary therapies and consultant and physiotherapy clinics. If necessitated, patients can be admitted for longer periods if the patient wishes this.

The MDT palliative team told us that they had carried out a lot of multi-disciplinary work with local care home staff, the ambulance service and social work to formulated advanced care planning document across agencies to facilitate patients being cared for at the end of their lives in the place of their choice. The resultant Respect document meant that if a paramedic was called to a care home the patient’s wish to remain there was honoured.

We observed a partnership service with between the trust and the local council whereby seven days’ worth of supplies of clean bed linen, pillowcases and towels were brought to the patients home every week and the used ones taken and laundered for free.

We observed staff collecting prescribed medicines from the general practitioner surgeries, getting it dispensed and then taking it to the patients’ homes to help the carers.

We observed several instances whereby patients were commenced on a fast track pathway to ensure they were transferred to their preferred place of death and that they had the correct equipment such as specialist beds, the correct staff visiting and supporting, the correct medication that it was anticipated they may need and sufficient information for all concerned.

The trust employed a team of complex care matrons to whom patients with long term conditions could be referred. Whilst this team, who were linked to general practitioner practices as the other teams were, did not get involved in all end of life care patients, they were involved in some that met their criteria. An example was educating patients with conditions such as chronic obstructive pulmonary disease, which is a lung disease characterised by chronic obstruction of lung airflow meaning the patient struggles to breathe.

We met with and interviewed the Macmillan physiotherapist whose role was to support anyone with a complex life limiting condition. More specifically, to support patients at the end of their lives to achieve what they want to achieve. She stated that she was proud to work in a team whereby the whole team ‘will drop everything and rearrange stuff to meet the needs of the patients’.

During our inspection we were shown copies of ‘My Future Care Plan’ which is a care planning document that the department have devised and gives to patients. This contains information that an individual can utilise to plan for their future choices of care as they near the end of their life such as where to end their life, funeral arrangements, putting their affairs in order and whether they wish staff to attempt resuscitation should their heart stop beating. There was an example in the booklet of how future care planning could help and there was space for them to document their wishes.

Contact numbers were given to patients and relatives once it had been identified that they required specialist palliative care. These telephone numbers meant that the patients and those close to them could access qualified assistance at any time of the day or night.
Meeting the needs of people in vulnerable circumstances

Leaflets and booklets were available to patients and their carers giving advice on such issues as their choice of where to die at home, planning their funeral, how to broach the subject of dying with those close to them, putting their affairs in order and organ donation. However, we saw no leaflets in differing languages.

Staff had access 24 hours per day and seven days a week to a telephone interpreting service for patients whose first language was not English. Staff were aware of how to access these services if required.

There was a specific area in both the electronic records and in the hand-held notes to record patients cultural and religious needs and wishes.

All staff that we spoke to were aware of the importance of meeting the cultural and religious needs of the patient and told us they always discussed these with the patient and their family.

Patients and their carers had a ‘Patient and Family Diary’ in which they could document any questions they had, comments, worries or concerns. These were reviewed regularly by visiting staff who would answer these either in person or documented if they were not present during the visit.

The team could refer patients to other allied health professionals such as occupational therapists or dieticians if required.

We were present in the Macmillan Healthcare team office when one member of staff was heard talking on the telephone to a relative and who offered an extra night sitting service, above the two that the patient had already received that week, to care for the patient and relative.

Access to the right care at the right time

Patients and their carers were given contact telephone numbers should they need advice or assistance outside of their visits.

In the trusts Re-Audit of the End of Life Care Document the target for dying in the patients preferred place of death is 80% and the community achieved 100%.

Overnight they were asked to telephone a central number and they would receive a telephone call back between half an hour to an hour time.

We were present during a telephone call from a patient’s relative stating that their condition had deteriorated. In response to the family’s request their home visit was brought forward by a week and an immediate general practitioner visit was arranged by the nurse for that evening to review medication and review the patient’s condition.

The palliative care nurses are linked to general practices and their caseloads are approximately 20 patients each. Whilst this number could vary dependant on the number of patients needing end of life care at each general practitioner, the team told us that they assist each other where possible to equalise the workload as much as possible.

The palliative care team worked seven days per week and saw patients to them in a timely manner.

Learning from complaints and concerns

Complaints
From February 2017 to January 2018 the trust received no complaints for community services for end of life care.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

All patients and relatives that are commenced on the ‘Care in the Last Days of Life’ pathway were given a leaflet entitled ‘Coping with Dying’. Within this leaflet are details of the Patient Advice and Liaison Service provided by the trust with contact details should they have a concern, complaint or compliment about the care they are receiving.

Following a drug administration error in a patient’s home, which resulted in no known harm, we observed a staff member advising the patient’s relative of their right to complain and the process of how to do this.

Minutes from trust mortality meeting group, dated 23 October 2017, highlighted that the group would prefer to consider devising a local Voices survey feedback form as opposed to regional in order to specific demographical feedback pertinent to their department.

Compliments

On the two community bases we were able to view several cards from relatives and carers of patients cared for by the team praising the care given by all members of the team. Patients and their families that we spoke to during our inspection were all positive about the staff and the care and support they had received.

We saw written feedback about the care provided by the Macmillan Community Palliative Care Team and the Macmillan Home Healthcare Team whom had supported patient to die at home in their preferred place and a direct quote stated ‘the most friendly, caring and professional group of people that I have ever encountered’.

We were shown documented feedback from six patients/relatives for the Community Macmillan Specialist Palliative Care Team which was all positive and all stated they would be extremely likely to recommend the service.

We were shown questionnaire feedback for the Specialist Palliative Care nurses and their seven day working and 100% (n = 6) of respondents stated that this was a beneficial way of working for patients, their relatives and other staff. None of the people questioned had to be admitted to hospital as a result and five of the six were able to stay in their homes with the support that the department put in place.

Is the service well-led?

Leadership

The service had an experienced leadership team with the appropriate skills, abilities and commitment to provide high quality services.

The team was led by one whole time equivalent palliative care consultant who also led the at the two hospitals, dividing his time between the three areas.

All staff that we spoke to in a leadership role had a good understanding of the importance of providing the best quality of care possible.

Staff knew who their senior managers were and they stated they were always visible and
approachable.

All staff we spoke to during our inspection said their managers were supportive.

We were told that that the new leadership team understand the service well and more specifically the patients’ needs.

Vision and strategy

The strategy for palliative and end of life care was devised collaboratively by the Northern Lincolnshire Multi-Agency End of Life strategy group which consisted of multiple organisations and individuals including the palliative care team at the trust.

The aim is to deliver the National End of Life Care Strategy in Northern Lincolnshire specific the demographics of this area.

Seven working groups have been set up to achieve the targets in their strategy and these include Specialist Palliative Care and the DNACPR task and finish group.

Staff told us their vision for end of life care was encompassed in the five priorities for care of the dying person and ‘our chance to get it right’.

Their ‘care in the last days of life documents’ ensured that the national and local ambition of palliative and end of life care 2015 – 2020 was being met. During our inspection we observed this documentation being completed in full.

Culture

Staff we spoke to were both passionate and proud about the care they provided to people using their services and to their loved ones.

All staff stated that morale was good in their team and that they felt valued by their managers, peers, patients and their loved ones.

We observed a positive culture throughout the whole team with no evidence of a bullying culture and a team in which staff felt well supported to develop in their career.

We spoke with a manager who acknowledged that there had been some strong characters in the teams but that she was rectifying this to improve the culture.

During our inspection we were informed about a trust wide initiative which is one of the five key priorities. The Pride and Respect initiative is their anti-bullying campaign.

The community palliative care team worked well with the relevant teams in the rest of the trust and felt there was good team working.

Governance

The managers and staff that we spoke with during our inspection knew about the quality issues, priorities and challenges within the service.

There were weekly team meetings for the community palliative care team, NLAG End of Life Strategy Implementation Group Work Programme meetings and Multi Agency End of Life Strategy Group meetings that promoted good governance practice by ensuring, for example, that patients voices are listened to, that they are involved in future planning of the service and that
they are providing a good service.

Staff we spoke to were clear about their role within the trust and how their team integrated within their teams and the other providers in end of life care within their catchment area.

We reviewed guidelines that were in date, such as a new one to guide staff about patients differing spiritual and cultural needs in end of life care. However, we observed that some documents and leaflets were out of date and as such there was a risk that staff would access out of date guidance. We escalated this to staff during our inspection and we were told it would be dealt with immediately.

**Management of risk, issues and performance**

One of the MacMillan Healthcare workers was the moving and handling assessor for the palliative care team to prevent staff injuries.

We were told that all community staff were risk assessed and, if appropriate, offered a lone worker device, which is a device to help safeguard lone working staff in the community. However, the majority of staff chose not to use one. We observed some staff wearing a device and some not.

We were shown an audit, and the ongoing work as part of the resulting action plan, to address the issue of controlled drug disposal which was highlighted during a previous CQC inspection.

Identified risks in the service were identified they were documented and reviewed regularly as part of the NLAG End of Life Strategy Implementation Group Work Programme.

**Information management**

Palliative care staff had access to an electronic integrated primary care record on which they recorded the care provided to each patient. All devices were password protected and during our inspection we observed that both the personal information technology devices and those based within the community hubs were locked in between users.

There was a flagging system in place built into both the hospital's electronic patient record system and that of the community that highlighted which patients had in place a DNACPR form to aid the patient’s wishes, and those that were taken in the person’s best interest, to be carried out.

At one of the community bases we saw ‘Staff experience boards’ upon which was differing information for staff. For example, this included patient feedback, duty of candour, the upcoming care quality commission visit and you said we did’. This latter example highlighted the different way children in the accident and emergency department were seen following feedback. However, there was no date visible to state when this board had last been updated.

The departments ‘Care in the Last Days of Life Document’ contained flowcharts to inform health professionals

A notice board in the community office highlighted the ‘priorities of care for the dying person’ which were listed as ‘recognise, communicate, involve, support, plan and do’.

**Engagement**

We were told about a bereavement questionnaire that the service had recently commenced as a pilot to get feedback from family and friends.
During the week of our inspection the department were making final preparations for their ‘Dying Matters’ week which was a week-long series of events held both within the trust and in the catchment area of their trust, such as manned information stands in the hospitals and at local shopping centres. The events are being sponsored by a local firm of solicitors and was organised by the trust, a local funeral director and the local Women’s Institute who are some of the members of the committee. Dying Matters is a coalition of individual and organisational members across England and Wales, which aims to help people talk more openly about dying, death and bereavement, and to make plans for the end of life.

End of life care training and updates on best practice were facilitated by the palliative care team at the trust for local care homes.

The service had recently held an end of life conference with invited speakers from external agencies and bodies and the feedback from the 85 attendees was very positive and highlighted that they felt more confident caring for people on the end of life care pathway and had increased their confidence in referring patients to the Macmillan end of life team.

Friends and family test results from 22 respondents showed that all would recommend the palliative care team. All of the comments were positive and one, who had received care and input from the team, that had been ongoing for several weeks stated ‘This has improved my condition by 100% within one day.

Learning, continuous improvement and innovation

The trust had identified that some inpatients of North Lincolnshire and Goole NHS Foundation Trust hospitals were discharged into the care of a general practitioner who would not be able to prescribe this range of anticipatory medications immediately. Therefore, they amended their policy to state that all patients being discharged from one of their hospitals would take home five days’ worth of anticipatory medicines should they need it until their respective general practitioner could arrange an ongoing prescription.

A therapy assistant employed by the trust and working as part of the team was the winning recipient of the NHS Employers award for outstanding achievement for ‘Putting life back into days for those living with a life limiting condition’.

The department worked with the local authority to provide a weekly bed linen service that is delivered clean and ready to use to the patient’s homes when they are receiving end of life care.