Northern Lincolnshire and Goole NHS Foundation Trust

Scunthorpe General Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Urgent and emergency services	
Maternity and gynaecology	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) undertook an announced inspection of Northern Lincolnshire and Goole NHS Foundation Trust between the 22 and 25 November 2016 and an unannounced inspection on the 8 December 2016. Following these inspections, the CQC 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 and a lack of escalation processes about the shortages was putting patients at risk.
- The lack of patient assessment and/or escalation of patients identified as being at risk was causing patients' safety to be compromised.
- There was insufficient management oversight and governance of the identified risks.

We undertook an unannounced inspection on 15 June 2017. The purpose of this was to follow up on the actions the trust had told us they had taken in relation to the Section 29A warning notice issued in January 2017. At this inspection we found the trust had not taken sufficient, timely action to address all our concerns.

CQC will not be providing a rating to Scunthorpe General Hospital for this inspection. The reason for not providing a rating is because this was a very focused inspection carried out to assess whether the trust had made significant improvement to services within the required time frame. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

At this inspection we found:

- There were still gaps in resuscitation equipment, medicine fridge temperature recording and cleaning checklists in the emergency department (ED).
- The completion of patient records in the ED remained variable. We saw gaps in pain, nutrition and hydration, falls and pressure damage risk assessments.
- There was no assurance that safeguarding assessments had taken place in the ED.
- Sepsis pathways were not always completed or completed fully and antibiotics were not always given in a timely manner.
- Staff in the ED had not completed Paediatric Early Warning Scores (PEWS) in most records we reviewed.
- We had security concerns regarding the electronic medicine key system for controlled drugs.
- Entry to the resuscitation room in the ED remained a security risk.
- Actual staffing levels did not always match the planned staffing levels in maternity and the ED.
- The World Health Organisation (WHO) surgical safety checklist was not consistently embedded in maternity.
- We found inconsistencies in how staff in the maternity service recorded delays in patient care.
- We saw that new processes had been implemented to allow oversight of risks and governance including a nursing dashboard. However, the evidence we found was not always consistent with the information recorded on the nursing dashboard.
- The trust had improved its capacity and demand planning, however, this had not been embedded across all specialties.
- The trust had some significant challenges to deliver against the referral to treatment standards.

However;

- The ED was now visibly clean and tidy.
- Emergency equipment in maternity was now checked in line with trust policies.
- A new children's waiting area and ambulance entrance had been opened in the ED.
- National early warning scores (NEWS) were recorded in all adult patients' notes we checked.

Summary of findings

- Clinical records in maternity were now completed in line with trust policy.
- New nursing documentation had been introduced in the ED.
- We observed staff in the ED offering patients food and drinks.
- The maternity service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce-planning tool.
- The trust had developed a maternity services escalation policy.
- We found that the management of patients with mental health problems in the ED had improved. The room was ligature free and a standard operating procedure had been introduced.

Professor Ted Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services		• The daily cleaning checklists and medicine fridge temperature recordings were not always completed daily. • The daily checking of resuscitation trolleys and emergency equipment remained inconsistent. • The completion of nursing documentation remained inconsistent. • Paediatric early warning scores (PEWS) were not completed in 89% of patient's notes. • We found that sepsis pathways were not always completed or completed fully and antibiotics were not always given in a timely manner. • Patients were not always assessed appropriately for nutrition and hydration, falls or pressure damage risk and this was not always documented. • We found no assurance that safeguarding assessments had taken place. • We had security concerns regarding the electronic medicine key system for controlled drugs. • Entry to the resuscitation room remained a security risk. • We found that 30% of nursing shifts were not filled with substantive staff. However; • The department was visibly clean and tidy, additional support workers had been employed to assist with this. • A new children's waiting area and ambulance entrance was open. • National early warning scores (NEWS) were recorded in all adult patients' notes we checked. • A shift handover sheet had been introduced where the shift leader allocated tasks. • A keypad had been installed on the medicine room in the majors' area. • New nursing documentation was in place. • Daily issues were discussed in the huddle and appropriately escalated. • We observed staff offering patients food and drinks.

Summary of findings

- We found that the management of patients with mental health problems had improved. The room was ligature free and a standard operating procedure had been introduced.

Maternity and gynaecology

- The World Health Organisation (WHO) surgical safety checklist was not consistently embedded.
- Actual midwifery staffing levels were often below the planned staffing level.
- The service had introduced a patient safety midwife. Their role was to audit maternity records and undertake safety checks on aspects of women's care. However, midwifery staffing levels were impacting on the ability to consistently carry out the role.
- High rates of staff sickness were having an impact on midwifery staffing levels. In June 2017, the sickness rate was 16%.
- We found inconsistencies in how the service recorded delays in patient care.

However;

- Processes had been put in place to ensure staff had checked emergency equipment.
- The service had commenced submitting data to the maternity safety thermometer.
- Clinical records were fully completed. We saw evidence of 'fresh eyes' and hourly assessment of cardiotocography (CTG) in line with trust policy.
- We saw evidence of appropriate escalation of women to the coordinator and plans were clearly documented using the situation, background, assessment and recommendation response (SBAR) tool.

Scunthorpe General Hospital

Detailed findings

Services we looked at

Urgent & emergency services; maternity and gynaecology.

Detailed findings

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Background to Scunthorpe General Hospital

Northern Lincolnshire and Goole NHS Foundation Trust provides acute hospital and community services to a population of over 361,850 people. The trust serves a population across North and North East Lincolnshire and the East Riding of Yorkshire. The trust's annual budget is around £330 million and it employs around 5,166 members of staff.

This trust has three hospital locations:

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

The trust provides community services in North Lincolnshire.

There are approximately 877 beds at the trust including 762 general and acute care, 72 maternity and 43 critical care beds.

The trust's main Clinical Commissioning Groups (CCGs) are North Lincolnshire CCG, North East Lincolnshire CCG and East Riding of Yorkshire CCG.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included one CQC inspection manager, five CQC inspectors, one CQC assistant inspector and three specialist advisors; two midwives and an ED nurse.

How we carried out this inspection

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

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

We undertook an announced inspection of Northern Lincolnshire and Goole NHS Foundation Trust between the 22 and 25 November 2016 and an unannounced inspection on the 8 December 2016. Following these inspections, the CQC issued the trust with a Section 29A warning notice which stated that the quality of health care provided by the trust required significant improvement.

Detailed findings

We undertook a further unannounced inspection on 15 June 2017. The purpose of this was to follow up on the actions the trust had told us they had taken in relation to the Section 29A warning notice.

CQC will not be providing a rating to Scunthorpe General Hospital for this inspection. The reason for not providing a rating is because this was a very focused inspection carried out to assess whether the trust had made significant improvement to services within the required time frame. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

The inspection team inspected the following core services at Scunthorpe General Hospital:

• Urgent and emergency care

• Maternity and gynaecology

We reviewed evidence provided by the trust and interviewed staff about the process, management and oversight of the outpatient waiting list backlog.

We also spoke with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, administrative and clerical staff and mangers. We observed how people were cared for, and reviewed patients' personal care and treatment records.

Facts and data about Scunthorpe General Hospital

- From February 2016 to January 2017 the trust had 152,623 ED attendances, 431,351 outpatient appointments, 95,455 inpatient admissions, 4,344 births, and 1,641 deaths.
- The catchment area of the trust includes people in North Lincolnshire and North East Lincolnshire. These localities span the area south of the Humber River, bordering the East Riding area, South and Central Lincolnshire and South Yorkshire. The health of people in North Lincolnshire is similar to the England average. Deprivation is similar to average and about 5,490 children live in poverty. Life expectancy for men is lower than the England average, and for women is similar to the England average. The health of people in North East Lincolnshire is generally worse than the England average. Deprivation is higher than average and about 28.5% (8,500) of children live in poverty. Life expectancy for both men and women is lower than the England average.
- From May 2016 to April 2017, the trust had one never event (in maternity) and 75 serious incidents.
- From March 2016 to February 2017 the trust reported 12,392 incidents with 98% categorised as low or no harm.
- Mortality data for the trust showed that from January to December 2016, the hospital standardised mortality ratio (HSMR) was within the expected range of 107.6 compared to an England average of 100. The summary hospital-level mortality indicator (SHMI) was higher than expected at 1.12. This was worse than the England average of 1.0.
- In the NHS Staff Survey (2016), the trust performed better than other trusts in one question, about the same as other trusts in 18 questions and worse than other trusts in 14 questions. Overall staff engagement ranges from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score was 3.68 which was in the bottom 20% of trusts.

Urgent and emergency services

Safe	
Well-led	
Overall	

Information about the service

Urgent and emergency care services are delivered by the emergency departments (ED) at Diana Princess of Wales Hospital and Scunthorpe General Hospital (SGH), which provide a 24-hour, seven-day a week service to the local population. Goole and District Hospital has a minor injuries department. In 2016/17, the trust had 151,765 attendances at its urgent and emergency care services.

The emergency department is a designated trauma unit. However, the most severely injured trauma patients are taken by ambulance or helicopter to the nearest major trauma centre, if their condition allows them to travel directly. If not, they are stabilised within the emergency department and either treated or transferred as their condition dictates. There is a protocol to inform the medical team which patient injuries require treatment at a major trauma centre. The department has a nearby area where the helicopter can land and a protocol is in place for the transfer of the patient into and out of the emergency department.

Summary of findings

CQC conducted an announced inspection of Northern Lincolnshire and Goole NHS Foundation Trust between the 22 and 25 November 2016 and an unannounced inspection on the 8 December 2016. Following these inspections, the CQC issued the trust with a Section 29A warning notice. This was because we had significant concerns relating to:

- The lack of appropriate systems in place to maintain cleanliness and to prevent the spread of infections.
- Equipment was not checked in line with trust policy.
- The lack of security in some areas of the department, for example, access to the resuscitation room was a security risk.
- Medicines and intravenous fluids were not always stored safely and securely.
- Staff did not perform comfort rounds, including pressure area care.
- Patients were not risk assessed and escalated appropriately.
- There was a discrepancy between the actual and the recorded arrival times of patients.
- We had concerns about the care of patients with mental health conditions.
- There was insufficient numbers of staff, available in line with national guidance and patient acuity and dependency.
- Nationally reported data, relating to the time to initial assessment of patients was not reported accurately.
- The leadership team had limited oversight of the departmental risks and governance processes.

We conducted this unannounced inspection on 15 June 2017 to specifically look at the concerns we highlighted within the Section 29A warning notice.

At this inspection we found:

Urgent and emergency services

- A daily cleaning schedule for trolleys had been introduced however; the checklists for these were not always completed daily.
- The daily checking of resuscitation trolleys and emergency equipment remained inconsistent.
- Entry to the resuscitation room remained a security risk.
- Daily medicine fridge temperature recordings had improved however, we found some days when these were not completed.
- The completion of nursing documentation remained inconsistent.
- Paediatric early warning scores (PEWS) were not completed in 89% of patient's notes.
- Thirty percent of nursing shifts were not filled with substantive staff.
- Sepsis pathways were not always completed or completed fully and antibiotics were not always given in a timely manner.
- The recording of pain scores remained inconsistent.
- Patients were not always assessed appropriately for nutrition and hydration, falls or pressure damage risk and this was not always documented.
- Security concerns regarding the electronic medicine key system for controlled drugs.
- No assurance that safeguarding assessments had taken place.

However we also found some improvements during this inspection including:

- The department was visibly clean and tidy, additional support workers had been employed to assist with this.
- A new children's waiting area and ambulance entrance was open.
- New nursing documentation was in place and national early warning scores (NEWS) were recorded in all adult patients' notes we checked.
- A shift handover sheet had been introduced where the shift leader allocated tasks.
- A keypad had been installed on the medicine room in the majors' area.
- Daily issues were discussed in the huddle and appropriately escalated.
- We observed staff offering patients food and drinks.
- The management of patients with mental health problems had improved. The room was ligature free and a standard operating procedure had been introduced.

Urgent and emergency services

Are urgent and emergency services safe?

We have not rated this key question because this was undertaken as a focused inspection to assess whether improvements had been made since we issued the trust with a Section 29A warning notice following our comprehensive inspection in November 2016.

At this inspection we found:

- A daily cleaning schedule for trolleys had been introduced; however, the checklists for these were not always completed daily.
- The checking of resuscitation trolleys and emergency equipment remained inconsistent.
- Entry to the resuscitation room remained a security risk.
- Daily medicine fridge temperature recordings had improved however; we found some days when these were not checked.
- The completion of nursing documentation was inconsistent. Patients were not always assessed appropriately for nutrition and hydration, falls and pressure damage risk and this was not always documented.
- Paediatric early warning scores (PEWS) were not completed in 89% of patients' notes.
- Thirty percent of nursing shifts were not filled with substantive staff.
- Sepsis pathways were not always completed or completed fully and antibiotics were not always given in a timely manner.
- Security concerns regarding the electronic medicine key system for controlled drugs.
- No assurance that safeguarding assessments had taken place.

However:

- The department was visibly clean and tidy, additional support workers had been employed to assist with this.
- A new children's waiting area and ambulance entrance was open.
- A shift handover sheet had been introduced where the shift leader allocated tasks.
- A keypad had been installed on the medicine room in the majors' area.
- New nursing documentation was in place and national early warning scores (NEWS) were completed for all adult patients.
- We observed patients being offered food and drinks.
- Daily issues were discussed in the huddle and appropriately escalated.
- We found that the management of patients with mental health problems had improved. The room was ligature free and a standard operating procedure had been introduced.
- Staff were aware of the safe staffing escalation procedures.

Cleanliness, infection control and hygiene

- During our previous inspection, we were not assured that there were the appropriate systems in place to maintain the cleanliness of the emergency department (ED) at SGH to prevent the spread of infections.
- Since the previous inspection, an additional ward support worker post had been introduced on a temporary basis. This provided an additional 62 hours per week support to the domestic services.
- Checklists for cleaning and stocking cubicles had been introduced. Tasks were allocated to the healthcare assistants and ward support workers. These tasks were signed, each day, to indicate they had been carried out. We checked the previous three weeks tasks and found the majority of jobs were completed however there were some gaps in the minors' area of the department.
- We looked at the domestic daily task sheets for the previous three weeks and found that all tasks were completed.
- Cubicle cleaning checklists had also been introduced. We looked at these for the previous week for four of the cubicles. All cleaning was completed except for one day in one of the cubicles.
- A trolley passport had been introduced. This was a daily cleaning schedule for patient trolleys which included a deep clean, mattress and brake check and restocking. Between the 1 June and 15 June 2017, we found that 10 of the 25 trolleys were checked daily, two were out of use. There was no evidence on the cleaning schedule that the remaining trolleys (13) had been cleaned daily including some that had not been cleaned for two or three days.

- We requested the matrons frontline ownership (FLO) audits that look at infection, prevention and control processes within the department. In May 2017, this showed an overall score of 85%.

Environment and equipment

- During our previous inspection, we were not assured that equipment was checked in line with trust policy and had concerns about the security in some areas of the department.
- Access to the resuscitation room remained a security risk, as there was no lock on the resuscitation room doors and access could be gained from the waiting room and the main department.
- During this inspection, we checked the resuscitation trolley in the majors department. We found the defibrillator was not checked for 13 days in April 2017, five days in May 2017 and three days in June 2017. The suction machine was also not checked for 14 days in April 2017, ten days in May 2017 and four days in June.
- In the paediatric resuscitation bay, we checked the defibrillator, this had been checked every day in April 2017, however in May 2017 there were three gaps, and there was one gap in June 2017. The suction machine was checked every day in April 2017; however, there were four gaps in May 2017 and two gaps in June 2017.
- We checked resuscitation bay two and found that the defibrillator was not checked for two days in April 2017, one day in May 2017 and one day June 2017.
- We checked resuscitation bay one and found that the defibrillator was not checked for four days in April 2017 and one day in June 2017. It was checked every day in May 2017.
- Other daily checks included checking the 'pod', which contained emergency equipment the documentation showed that these were checked most days.
- Since the last inspection the service had implemented a 'coordinator shift handover sheet', this included a checklist to ensure that tasks were allocated to staff, such as the checking of the resuscitation equipment, staff signed after completing the tasks. We looked at the sheets for the previous four days and found that tasks had been allocated and completed for three of the four days.
- The new children's waiting room, which was under construction during our last visit, had been completed. This provided a separate waiting room for children which had toys and a designated toilet with baby change facilities
- The new ambulance entrance, which was under construction during our last visit, was also completed, providing a separate entrance for patients arriving by ambulance. This had a key pad on the outside for ambulance crews to gain entry.
- At our previous inspection, the seating in the main waiting room did not face the reception. The seats were now positioned facing the reception, which allowed staff to observe the patients waiting in the waiting room. However the chairs were loose and lightweight which could be deemed as potentially dangerous if they were thrown by someone.

Medicines

- During the previous inspection we found medicines and intravenous fluids were not always stored safely and securely.
- At this inspection we saw that a new keypad had been installed on the medicine room in the majors' area.
- We checked medicines requiring cold storage and found daily fridge temperatures were in within the recommended ranges, however, they had not been recorded for two days in April and for four days in May 2017.
- At this inspection, we found daily controlled drug (CDs – medicines that require extra checks and special storage arrangements because of their potential for misuse) balance checks were not always carried out. Between 1 May and 15 June 2017, we found checks had not been carried out on three days.
- An electronic key system was used to access CDs. This system recorded the date, time and name of the person accessing the cupboard. Registered nurses had their own key.
- We looked at the 'the medicines code: policies and procedures for the use of medicines in Northern Lincolnshire & Goole NHS Foundation Trust. Part 5 of 6. Controlled drugs'.
- In section 5.4.2 Key Holding and Access to CDs, the policy states:
  - There must be only **ONE set of keys** to the controlled drugs cupboard(s) in the ward or

department etc. The controlled drug keys must be on a separate key ring to other medicines cupboard (or other) keys, although for practical use, they may be connected with a detachable link
    - The appointed registered nurse or midwife in charge can delegate control of access (i.e. key holding) to the CD cupboard cabinet to another, such as a registered nurse or midwife or Registered Operating Department Practitioner (ODP). However, legal responsibility remains with the appointed registered nurse or midwife in charge. Whilst the task can be delegated, the responsibility cannot
    - The controlled drug key should be returned to the nurse or midwife in charge as soon as possible after use by another registered member of staff.
- This meant that the staff in the ED were failing to adhere to the trust's medicine policy. We raised this with the trust at the time of the inspection.
- We looked at patients notes who had been prescribed antibiotics; we found that seven (78%) of nine patients had not received these in a timely way

Records

- During our previous inspection, we did not observe any comfort rounds, including pressure area care, being performed
- We reviewed 16 patients' records. Six of the patients' records were from 8 January 2017; these patients had been reported as breaching the 12 hour ED standard. These patients were in the department between 18 hours 13 minutes and 23 hours 28 mins. We looked at the completion of nursing documentation which included care round documentation and found that this was inconsistent. Two (33%) of the six records had no care round documentation, this meant there was no record of pressure damage risk, or pressure area care being provided. There was no evidence that a falls assessment risk had been completed in any of the records.
- We reviewed the records of a further nine adult patients, which had been completed following the introduction of new nursing documentation. We found that three (33%) of the nine records had no documented care rounds or assessment of pressure damage risk.
- We reviewed 21 sets of adult patients' notes for the completion of pain scores, of these 14 (67%) did not have a pain score recorded; however nine (43%) patients had received pain relief.
- We looked at the records of nine paediatric patients and found that none of these had a pain score recorded; however, six patients (67%) had been given pain relief.
- We viewed 21 records and 17 (81%) showed that the patient had been offered food and drink or that the patient was nil by mouth. During this inspection, we observed patients being offered food and drinks.
- We looked at the records of five patients who were in the department at the time of this inspection and found that all of these the patients had documented nursing assessments and care rounds were in place.
- The new nursing documentation did not allow any documentation of a safeguarding assessment. It allowed staff to document if a safeguarding referral had been completed. This did not provide assurance that a thorough assessment regarding safeguarding had taken place.
- We looked at 28 sets of patient notes; one had a documented safeguarding referral. We could not identify if the others (96%) had received an appropriate safeguarding assessment.

Assessing and responding to patient risk

- A national early warning score (NEWS) system for acutely ill patients was used. This supports the process for the early recognition of patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- During our previous inspection, we found limited assurance that patients NEWS were completed and patients were escalated appropriately.
- We checked 20 adult patient care records and found that NEWS scores were recorded in all of the records we reviewed.
- We viewed a 'snap shot' audit of the NEWS scores which had taken place in March 2017. This showed 100% compliance in the monitoring of vital signs, a documented management plan and evidence of appropriate action taken.
- A similar paediatric early warning score (PEWS) was used for early recognition of children who were becoming unwell. We looked at nine children's records and found that only one (11%) had a PEWS score documented.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration.

- The trust's published data for the median time from arrival to initial assessment was worse than the overall England for two of the last 12 months. In February 2017, the median time to initial assessment was 29 minutes compared to the England average of seven minutes. The trust initial time to assessment was consistently reported as one minute up until January 2017.
- During our inspection in November 2016, we raised this as a concern because this was not consistent with our observations.
- At this inspection, we looked at the records of 16 patients who arrived by ambulance and found the average time to initial assessment was 36 minutes, which was worse than the England average.
- We observed five patients arriving by ambulance and these were registered between 12 and 25 minutes of arrival.
- Between May 2016 and April 2017, there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In April 2017, 69% of ambulance journeys had turnaround times over 30 minutes.
- The RCEM recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet this standard for seven months in the 12 month period from March 2016 to February 2017. In February 2017, the median time to treatment was 72 minutes. This was worse than the England average of 57 minutes.
- We looked at 12 recent sets of patient notes and found the time of arrival to receiving treatment was, on average, 49 minutes.
- During our previous inspection, we had concerns about the care of patients with mental health conditions.
- We looked at the care and management of patients who had mental health problems. During this inspection, there were no patients with mental health problems being cared for in the department.
- We viewed the room in which patients would be nursed. This was now ligature free. The room was opposite the nurse's station allowing staff to observe patients in the room. The room had a panic alarm, two-way opening doors that could not be locked from the inside and the doors had observation panels.
- A standard operating procedure pathway, for the management of patients with a mental health problem, had been introduced a week before this inspection. This did not allow staff to document what actions were taken, however, it was a pilot and feedback was encouraged. We found that training on completion of the new document was varied.
- Staff we spoke with had received some training on mental health awareness; some staff told us that this was not mandatory. Staff told us that most education was received in the huddles and teaching sessions. Huddle notes confirmed that a discussion had taken place regarding the mental health act.
- We looked five sets of patients' notes who had presented with mental health issues and all showed completion of the standard operating procedure.
- We reviewed the notes of six patients to check the management of sepsis and ensure that care was delivered in line with the RCEM guidance.
- We did not find a sepsis pathway in the notes of two (33%) patients who should have had a sepsis pathway completed, two (33%) patients had a pathway in place however, these were not fully completed and two (33%) patients had a fully completed pathway in place.
- We were informed that the audit department completed sepsis audits and that these were presented each month to staff in the department huddles. However, we found that the audits were based on patients that staff had diagnosed with sepsis; therefore, this did not identify patients who should have been diagnosed with sepsis and placed on a pathway that were not.

Nursing staffing

- During our previous inspection, we had concerns that there were insufficient numbers of staff, available in line with national guidance and patient acuity and dependency.
- At the time of this inspection, the department was fully staffed for the day shift. The night shift had one registered nurse less than the planned levels. This had been escalated to the duty matron and the shift had gone out to agency to try and provide cover.
- We checked eight weeks of nursing rotas between 24 April and 11 June 2017. We found that 30% of nursing shifts were vacant, 21% of these shifts were registered nurse (RN) shifts, 5% were emergency nurse practitioner shifts and 4% were healthcare assistant shifts.
- We found that bank or agency staff covered 18% of these shifts.
- We looked at the current registered nurse establishment and vacancies and found that the department had a

budget for 11.3 whole time equivalent (wte) band 6 and 7 RNs and 34.8 wte band 5 RNs. Figures provided by the trust showed that as of 31 May 2017 the department was over the establishment for band 6 and 7 RNs by 1.4 wte and under establishment for band 5s by 2.9 wte. This gave an overall deficit of 1.4 wte RN's.

- The action plan, created following the trust being issued with a Section 29A warning notice, stated that a review of the staffing establishment had taken place and this was due to be presented at the resource committee however the outcome of this was not known at the time of the inspection.
- Any staffing shortages were discussed in the daily huddle and escalated to the matron and the department manager.
- We spoke with staff who were able to describe the process of escalation and the escalation procedure was available on the intranet.

Are urgent and emergency services well-led?

We have not rated this key question because this was undertaken as a focused inspection to assess whether improvements had been made since we issued the trust with a Section 29A warning notice following our comprehensive inspection in November 2016.

At this inspection we found:

- The trust had implemented processes to allow oversight of risks and governance including a nursing dashboard. The evidence we found at this inspection was not always consistent with the information recorded on the nursing dashboard.
- We reviewed the care and treatment of patients with sepsis, and found that this did not always correlate with the trust's audit of these patients. At this inspection, we found inconsistencies, for example, not all patients with sepsis had a sepsis pathway in place.
- The ED leadership team had set up an ED working group to monitor and progress actions that flowed from the previous inspection.

Governance, risk management and quality measurement

- During our previous inspection, we had concerns that the nationally reported data, relating to the time to initial assessment of patients was not being reported accurately. At the time of this inspection, we found that the system for the recording of the time to initial assessment had been reviewed and changed.
- We saw gaps in the medicine fridge and controlled drug checks.
- We looked at the nursing dashboard for four weeks in March 2017. This showed that care rounds were completed in 80-100% of records and pressure area assessments were completed for 100% of patients. At this inspection, we were not assured about the accuracy of the trust's audits because we found that record keeping was variable. We found gaps in the recording of pain scores, pressure risk and falls assessments
- The trust was auditing the notes of patients who had been diagnosed with sepsis; however, the care and treatment of these patients did not always show that they were placed on a sepsis pathway or that they received antibiotics in a timely manner. The trust did not use a process of auditing a random selection of patient records therefore they did not identify patients where staff may have missed a diagnosis of sepsis.

Leadership of service

- The ED leadership team reviewed nurse staffing establishment three months prior to the inspection and compiled a business case.
- We found that staff were aware of the ED Improvement Plan; created following the Section 29A warning notice.
- The ED leadership team had set up an ED working group to monitor and progress actions that flowed from the previous inspection; progress on the actions was discussed at departmental meetings and elements were highlighted during staff huddles.

Maternity and gynaecology

Safe	
Well-led	
Overall	

Information about the service

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

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

During our inspection, we visited the maternity unit and spoke with ten members of staff including matrons, ward managers and midwives. We reviewed five sets of maternity records and seven observation charts. We also spoke with members of the management team who are responsible for the leadership and oversight of the service at Scunthorpe General Hospital, Diana Princess of Wales Hospital and Goole District Hospital.

Summary of findings

CQC conducted an announced inspection of Northern Lincolnshire and Goole NHS Foundation Trust between the 22 and 25 November 2016 and an unannounced inspection on 8 December 2016. Following these inspections, the CQC issued the trust with a Section 29A warning notice. This was because we had significant concerns relating to:

- The sharing of lessons learnt following serious incidents.
- Gaps in the emergency equipment checklists.
- Inconsistent record keeping in relation to the completion of the world health organisation (WHO) safety checklist, cardiotocography (CTG) reviews and 'fresh eyes' resulting in a failure to recognise the need for patient escalation.
- Staffing levels did not always meet the planned levels and the midwife to birth ratio was worse than national guidance.
- There was no dedicated anaesthetic cover for the service. Staff did not have a formal process to follow to access anaesthetic support out of hours which led to delays in care for women in labour.
- The risk and governance processes in maternity services.

We conducted this unannounced inspection on 15 June 2017 to specifically look at the concerns we highlighted within the Section 29A warning notice.

At this inspection we found:

- The World Health Organisation (WHO) surgical safety checklist was not consistently embedded. Following a review of five sets of patient records, we found the checklist was not complete in any of the records.
- Actual midwifery staffing levels were often below the planned staffing level.
- We found inconsistencies in how the service recorded delays in patient care.

Maternity and gynaecology

- Midwifery staffing levels were impacting on the ability of the patient safety midwife to consistently carry out the role.
- The service had carried out a patient safety culture assessment with all managers and an action was to complete this with all midwives, however, at the time of the inspection this had been put on hold.
- One of the actions the service said it had completed was to implement a patient safety strategy. We found that this had not been completed at the time of the inspection.
- Risk registers were not displayed in clinical areas.
- The service had implemented processes to allow oversight of risks and governance. The evidence we found was not always consistent with the trust findings

However we also found some improvements during this inspection including:

- Adult and neonatal emergency equipment had been checked in line with the trust policy.
- The service had commenced submitting data to the maternity safety thermometer.
- We saw evidence of appropriate escalation of women to the coordinator and plans were clearly documented.
- The service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce planning tool.
- The trust had developed a maternity services escalation policy for staffing shortages and a pathway to outline how to contact an anaesthetist if women required an epidural.

Are maternity and gynaecology services safe?

Incidents

- During our inspection in November 2016 we were not assured that:
  - Lessons learnt following a never event of a retained vaginal swab in February 2016 had been fully embedded.
  - The process for swab checks was embedded. A live drill to observe if actions put in place following never events relating to retained swabs was carried out. The drill identified that although policies and procedures had changed they were not fully embedded. For example, the use of white boards and clear trays was not consistently adhered to.
- During this inspection we found:
  - The service had improved how lessons learnt from incidents were disseminated. We saw posters outlining lessons learnt from incidents were displayed in the staff room on ward 26 and incidents were also discussed at ward briefings.
  - The service had developed a policy for checking swabs, instruments and needles; this included the use of clear trays to assist with swab counting. The policy had been approved in February 2017.
  - The service completed monthly audits to assess if swab checks were being carried out following delivery, fetal blood sampling or suturing. The results demonstrated an improvement and in May 2017 SGH was 100% compliant with all swab counts with the exception of during swab counts during normal delivery (97%)
- A quarterly newsletter from the women and children's group included summaries of lessons learnt from incidents.
- The service ran further simulation exercises to support the learning of lessons from serious incidents. In May 2017, they ran a simulation exercise for shoulder dystocia.
- A patient safety midwife had been introduced to review records and complete safety checks to provide assurance. However, during times of staff shortages, the patient safety midwife often worked clinically.

Maternity and gynaecology

Safety thermometer

- The maternity safety thermometer allows maternity teams to monitor and record the proportion of mothers who have experienced harm free care. At the previous inspection in 2016 we found the service did not submit information to the maternity safety thermometer.
- The service had commenced collating and submitting data to the maternity safety thermometer in January 2017. We saw this was displayed in staff offices and included on the safety improvement bulletin. However, this information was not visible to members of the public.

Environment and equipment

- During our inspection in 2016, we found gaps in the daily checking of advanced resuscitation equipment on the inpatient areas.
- At this inspection, we checked adult resuscitation equipment, emergency equipment and neonatal resuscitation equipment. Each trolley had a laminated copy of the trust's policy outlining the frequency of checks.
- During this inspection we found that equipment checks had improved;
  - On the central delivery suite (CDS) between February 2017 and June 2017 the neonatal resuscitation trolley had been checked on 107 of 109 days, the postpartum haemorrhage trolley had been checked on 108 days and the pre-eclampsia trolley was checked on 104 days.
  - On ward 26, between February 2017 and June 2017 all checklists were fully completed.
  - The service had conducted an audit of adult resuscitation trolleys. Results from April 2017 demonstrated 100% compliance with weekly checks.
  - Environmental checklists had been revised and were completed by a healthcare assistant. On ward 26 we reviewed the checklist and found they were fully completed.

Records

- During our inspection in 2016, we found that a lack of patient assessment, and escalation of patients identified as being at risk had compromised patient safety. We found 55% of records had no evidence of hourly cardiotocography (CTG) reviews or fresh eyes. This was not in line with the service's policy which stated that an hourly systematic assessment of the CTG trace must be recorded and that every two hours the practitioner providing care must seek the assistance of a colleague to systematically review the CTG trace.
- At this inspection we found some improvements. We reviewed five sets of records and found that there was evidence of fresh eyes and hourly assessment of CTGs. We saw evidence of appropriate escalation of patients to the coordinator and plans documented.
- The patient safety midwife was responsible for reviewing patient records and ensuring that CTG reviews and fresh eyes were completed. Any areas of non-compliance were escalated to the leadership team.
- The service had completed an audit of antenatal and intrapartum CTG monitoring. In April 2017, they found 98% of records had evidence of fresh eye reviews; this had improved from 58% in August 2016. The audit also showed that 99% of antenatal CTG's were commenced within 30 minutes of a woman's arrival.

Assessing and responding to patient risk

- Within maternity services staff used the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient's clinical condition was changing and prompted staff to get medical support if a patient's condition deteriorated.
- During our inspection in 2016, the services audit of MEOWS identified that when escalation was required, only 58% of records had evidence of appropriate escalation, referral and a management plan.
- At this inspection, we found some improvements. MEOWS were recorded on paper observation charts. We reviewed seven charts and found the score was correctly calculated on five charts (71%) and where appropriate women had been escalated in a timely manner. However, on two charts patients were not escalated as per the trust's policy.
- The service completed spot checks on the completion of MEOWS. Results from December 2016 and January 2017 at SGH showed 100% of MEOWS charts were fully completed.
- Staff used situation, background, assessment and recommendation response (SBAR) stickers to document actions they had taken.

- The World Health Organisation (WHO) surgical safety checklist is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications.
- At our previous inspection we found that WHO checklists were not being consistently completed. At this inspection, we reviewed five sets of records and found the WHO surgical safety checklist was not fully completed in any of the records. In one set of records an out of date old version of the checklist had been used. This meant that we did not see any improvement.
- In February 2017 the service completed an audit of the WHO surgical safety checklist within obstetrics. At SGH the audit reviewed 25 sets of records and found limited assurance. Compliance with the sign in ranged from 71% to 100%, compliance with the time out ranged from 63% to 71% and compliance with the sign out ranged from 38% to 54%. This was worse than the trust target of 100% compliance.
- In March and April 2017, spot check audits of the WHO surgical safety checklists conducted by the patient safety midwife showed a compliance rate of 97%. Our findings at the time of this inspection meant that we were not assured about the trust's audit results.
- Staff completed annual K2 training (an interactive computer based training system that covered CTG interpretation and fetal monitoring). At the time of the inspection 52% of midwives (38 out of 72) and) and 38% of medical staff (five out of 13) had completed the K2 training.
- The service had implemented a fetal monitoring workbook to support the service's CTG mandatory training. The workbook was based on national guidance. As of April 2017, 95% of staff were compliant with CTG mandatory training. This had increased from 69% in November 2016.
- The service was planning to introduce CTG champions.
- In January 2017, the service had introduced patient safety midwives. Their role was to audit maternity records and undertake safety checks on aspects of women's care. They reviewed the following:
  - Was a CTG commenced within thirty minutes?
  - Was there evidence of CTG review and 'fresh eyes'?
  - Was there evidence of clinical escalation?
  - Was there a clinical management plan in place?
  - Had women received responsive and appropriate analgesia?
  - Was there evidence of proactive communication with the obstetric and anaesthetic team?
  - Had the WHO checklist and swab counts been completed?
  - Had the service's escalation policy been followed?
  - Had emergency equipment been checked?
  - Had any lessons learnt been communicated to all staff?

Midwifery staffing

- The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommend a ratio of one midwife to 28 births (1:28). In May 2017, the midwife to birth ratio at SGH was 1:27. This had improved since our previous inspection where the ratio was 1:30.
- Staffing levels were displayed on the entrance to all wards.
- We reviewed planned and actual midwifery staffing levels from 22 May to 16 July 2017 and found 27% of qualified day shifts were below the planned staffing levels and 24% of qualified night shifts were below the planned staffing levels.
- Staff reported that midwifery staffing levels remained a challenge. This was due to staff vacancies and high levels of staff sickness. The sickness rate in June 2017 was 16%. Ward 26 and the CDS had 2.4 whole time equivalent qualified staffing vacancies. There was also one vacancy in community services.
- In November 2016, we found that staffing levels were impacting on care and delays in treatment were occurring. At this inspection we reviewed incident data and found from January to June 2017, 81 incidents were reported that related to staffing levels, however there was no evidence that this had impacted on care or caused delays in treatment.
- As part of the service's escalation process staff from the community midwifery team were called in to work on the unit. From January to June 2017, there were 25 incidents when the community midwifes were called into the unit.
- RCOG guidelines state that co-ordinators should be supernumerary. Incident data from January 2017 to June 2017 showed eight occasions when co-ordinators had to take a clinical caseload.

- There was one patient safety midwives who was supernumerary. However, staff said that due to challenges with staffing levels they were not always supernumerary and had to take on clinical roles.

Medical staffing

- At the previous inspection in November 2016, it was identified that the maternity unit did not have a dedicated anaesthetist, out of hours the anaesthetist was based on the critical care unit and provided cover to the unit.
- At this inspection, we found dedicated anaesthetic cover was available on the labour ward during the day. From 6pm to 8:30am, anaesthetic cover was available with the anaesthetist also providing a service to the critical care unit and theatres. There was an additional on-call anaesthetist if required.
- The service had introduced a twice daily multidisciplinary handover that discussed any potential needs for epidurals.
- The patient safety midwife reviewed the time to epidural as part of their review of patient records.
- The service had developed a pathway to outline how to contact an anaesthetist if women required an epidural. The trust provided a copy of this and showed the processes for midwives to follow during normal working hours and outside these times. It also showed the expected response times however it did not give any guidance of the process to follow if an anaesthetist failed to respond.

Are maternity and gynaecology services well-led?

We have not rated this key question because this was a focused inspection to assess whether improvements had been made after we issued the trust with a Section 29A warning notice following our comprehensive inspection in November 2016.

At this inspection we found:

- The service had carried out a patient safety culture assessment with all managers and an action was to complete this with all midwives, however, at the time of the inspection this had been put on hold.
- One of the actions the service said it had completed was to implement a patient safety strategy. We found that this had not been completed at the time of the inspection.
- Risk registers were not displayed in clinical areas.
- The service had implemented processes to allow oversight of risks and governance. The evidence we found was not always consistent with the trust findings for example the service audits of the WHO checklist.

However we also found:

- The service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce planning tool.
- The trust had developed a maternity services escalation policy.
- The service had developed a pathway to outline how to contact an anaesthetist if women required an epidural.

Governance, risk management and quality measurement.

- At our inspection in November 2016, we were not assured that the governance processes were sufficiently in place and implemented in maternity services.
- The action plan, created following the trust being issued with a Section 29A warning notice, stated that risk registers would be displayed in clinical areas. At this inspection we did not see evidence of this.
- Since our inspection in November 2016, the service had completed a review of staffing levels using the Birthrate Plus® midwifery workforce planning tool. The review indicated that SGH should reduce the establishment on ward 26 by 1.4 whole time equivalents and increase the establishment on the antenatal day unit by 2.6 whole time equivalents. In June 2017, the service had submitted a business case to implement the recommendation from Birthrate Plus®.
- The trust had developed a maternity services escalation policy for staffing shortages. We saw evidence of this been ratified during a clinical governance meeting in February 2017. The policy included a risk assessment tool that was completed during times when concerns were raised regarding patient safety being compromised and if there was a potential for patient harm.
- Following the previous inspection the trust said they had raised awareness with staff regarding the need to report any delays in patient care. We reviewed information submitted by the trust and found

inconsistencies in the way delays in patient care were reported. For example, incident data from January to June 2017 reported no delays in patient care. However, upon reviewing the maternity services risk assessment tool (a form that was completed when there was a risk to patient care) on 17 May 2017 the maternity risk assessment form stated there were five midwives working across the central delivery suite (CDS) and ward 26 and the service had delayed induction of labour as part of their escalation process. However, this was not reported as a red flag on the service's incident reporting system.

- The service had developed a pathway to outline how to contact an anaesthetist if women required an epidural. The trust provided a copy of this and showed the processes for midwives to follow during normal working hours and outside these times. It also showed the expected response times however, it did not give any guidance of the process to follow if an anaesthetist failed to respond. At the time of the inspection, the trust had not audited compliance with the pathway.
- The service had also produced a standard operating procedure for the use of the main theatre at SGH as a second theatre when the obstetric theatre on the CDS was in use or out of hours.
- The service had introduced patient safety midwifes. Their role was to review records and complete safety checks to provide assurance. One of their checks included reviewing swab checks and documentation. If non-compliance was identified, they would discuss it with the individual and escalate any concerns to the leadership team. The service had implemented a zero tolerance approach and produced a policy to support this approach.
- In September 2016, the service had introduced 'together we are safe to care' daily walk rounds. The walk rounds were completed by the matron and included checking staffing levels and skill mix, bed status and any overnight concerns. Elective admissions, red flags for staffing and acuity concerns, safeguarding, potential complaints were reviewed as well as spot checks of the ward area safety checklists, to ensure that these had been competed in each area. Any gaps would be raised with the shift leads. We looked at the back dated matrons checklists and saw that these had been completed five times in April 2017, six times in May 2017 and seven times in June 2017.
- The service had revised the daily checklist to include the checking of resuscitaires including portable resuscitaires.