**We are the regulator:** Our job is to check whether hospitals, care homes and care services are meeting essential standards.

### Diana Princess of Wales Hospital

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<tr>
<th>Scartho Road, Grimsby, DN33 2BA</th>
<th>Tel: 01472874111</th>
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<tr>
<td>Date of Inspections: 05 December 2013</td>
<td>Date of Publication: February 2014</td>
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We inspected the following standards as part of a routine inspection. This is what we found:

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<th>Standard</th>
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<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>✓</td>
</tr>
<tr>
<td>Staffing</td>
<td>✓</td>
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<tr>
<td>Supporting workers</td>
<td>✓</td>
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<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓</td>
</tr>
<tr>
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### Details about this location

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<th>Registered Provider</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
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<tr>
<td>Overview of the service</td>
<td>Diana Princess of Wales Hospital is an acute hospital, run by Northern Lincolnshire and Goole NHS Foundation Trust. The trust serves the population of North East Lincolnshire and surrounding areas. The hospital has around 430 beds and provides acute, elective and specialist care.</td>
</tr>
<tr>
<td>Type of services</td>
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 December 2013 and 5 December 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and/or family members, talked with staff and received feedback from people using comment cards. We reviewed information sent to us by commissioners of services, reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities and reviewed information sent to us by local groups of people in the community or voluntary sector. We talked with commissioners of services, talked with other regulators or the Department of Health, talked with other authorities and talked with local groups of people in the community or voluntary sector. We were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

The inspection at Diana Princess of Wales Hospital was carried out to assess whether Northern Lincolnshire and Goole NHS Foundation Trust (the trust) had implemented actions in response to non-compliance found at the inspection in February 2013. This was in relation to patient care in the accident and emergency department (A&E), stroke care, supporting staff to receive appropriate training and professional development and the quality of record keeping. As part of this inspection we also looked at maternity care and also the quality of care provided to support patients with dementia to maintain their physical and mental health and wellbeing as part of a themed inspection programme. This programme looked at how provider's worked together to provide care to people with dementia and at people's experiences of moving between care homes and hospital.

We spoke with over 60 patients or their relatives and staff. The inspection team comprised CQC inspectors, doctors, nurses and patient representatives. We received information from local bodies such as the clinical commissioning groups, Healthwatch, Monitor, NHS
Most patients we spoke with told us they had received a good standard of care. They told us they had been treated with dignity and respect. They said they did not have to wait long before receiving treatment and that staff had kept them fully informed about their plan of care. Patients told us they had received pain relief in a timely way and felt that the care had met their individual needs.

Our review of the trust showed they had made progress in taking action to improve patient care and treatment in the areas we visited. We saw elements of good practice particularly in A&E and in the treatment of patients suffering from a stroke. The trust acknowledged that there was still work to be done to ensure there was continuous and sustained improvement to maintain patient safety and welfare. There had been changes to medical leadership and new directorate structures were being introduced in January 2014. This would ensure greater accountability at Board and ward level for patient care and safety.

Patient's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the trust worked in co-operation with others such as commissioners, GPs, other trusts, ambulance services and community services. There were systems in place to minimise the risk to patients care and treatment during their transfer and discharge.

There were enough qualified, skilled and experienced staff to meet patient's needs. The trust had management structures, systems and procedures which were followed, monitored and reviewed to enable the effective maintenance of staffing levels.

Patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Good progress had been made to ensure all staff received mandatory training and appraisal. Staff morale was noted to have improved in most areas.

The provider had an effective system to regularly assess and monitor the quality of service that patients received. There were structures in place to ensure governance arrangements were met at corporate and ward level. Complaints management was an area which the trust recognised required further improvement.

Although we saw some gaps in medical record entries, the trust was proactive in monitoring and improving the quality of patient records.
You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

| Care and welfare of people who use services | Met this standard |
| People should get safe and appropriate care that meets their needs and supports their rights |

**Our judgement**

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure patient's safety and welfare.

**Reasons for our judgement**

During our inspection in February 2013 we found patients were not receiving care and treatment which met their individual needs or ensured their welfare and safety. The trust had higher than expected mortality rates in stroke and respiratory disease and there were issues with clinical handover and triage arrangements in A&E.

At this inspection we found the trust had made progress in taking action to improve patient care and treatment in these areas and we saw elements of good practice. The trust acknowledged that it was 'work in progress' and recognised that continuous and sustained improvement was required to maintain patient welfare and safety.

On the whole patients told us they had received a good standard of care. They told us they had been treated with dignity and respect. Patients we spoke with told us they did not have to wait long before receiving treatment. They said staff had kept them fully informed about their plan of care. Patients said they had received pain relief in a timely way and felt that the care had met their individual needs. Most patients or their relatives said they would recommend the hospital to their family and friends. They said, "From all my hospital experiences I would" and "Yes they are fantastic here." Two relatives said they would not recommend the hospital because they had a poor experience in the past. One relative said, "Those memories remain with you and you are always wary."

We visited A&E and saw improvements in triage arrangements for patients on admission to the department. A trained nurse conducted an initial assessment using a system to prioritise the patient's care. This reduced unnecessary delays and improved patient flow. Patients told us they did not have to wait long before they received treatment. They said staff had kept them fully informed about their plan of care. Patients said they had received pain relief in a timely way and felt that the care had met their individual needs.

The clinical handover procedures in A&E were effective. The lead consultant told us handover was attended by several grades of staff including junior doctors. The handover
occurred throughout each shift and patient care was regularly discussed. Junior doctors confirmed they could approach senior staff at any time to discuss patient care. Staff confirmed the handover process was working very well. This ensured patient needs were being met.

The delivery of care and treatment was based on guidance issued by appropriate professional and expert bodies. The trust had developed a number of clinical pathways for care. These included pathways for stroke and respiratory disease. Assessment tools were used to establish the diagnosis and clear processes were in place to ensure patients were transferred to appropriate wards within specific timescales. This meant patients received the right care promptly and in the right place.

The trust's internal reporting showed improvements had been made in reducing mortality rates in stroke and respiratory disease. We spoke with a patient who had been transferred from the acute stroke unit at Scunthorpe hospital. They said, "Everything was explained to me and I have had five star treatment. I am so happy with the way I have been looked after."

Across the wards we inspected there were systems in place to assess patient needs and plan their care. Staff consulted the right colleagues to ensure that patients received the most appropriate support. They reviewed patients' health frequently and asked specialist doctors and other healthcare professionals to help with assessments and review treatment plans.

Risk assessments were in place. To minimise the risk of falls, patients were offered red socks and a red wrist band to indicate their high risk of falls to staff. Where necessary staff initiated hourly checks and encouraged relatives to participate in falls prevention by extending visiting times. A quality matron and ward falls champions on the wards were identified to develop and monitor practice. The matron told us patient reviews showed falls assessments were completed at admission and the correct management plan put in place. This had led to a 16% reduction in the number of falls in the trust. The frequency and underlying causes of falls were discussed with ward managers and further action taken where required. This ensured measures were in place to minimise the risk of patient falls.

The management of pressure care was monitored and reviewed. The Chief Nurse told us significant improvements had been achieved to reduce the number of hospital acquired pressure ulcers. The trust had a pressure ulcer action plan in place which was monitored by the Chief Nurse and a Non-Executive Director. Weekly meetings were held with key members of staff and all grade 3 and 4 pressure ulcers were investigated and appropriate action taken. The Chief Nurse told us training for staff on pressure care was provided at the patient bed side. Staff told us they had pressure ulcer champions on the wards who shared good practice. The Chief Nurse told us there were no avoidable pressure ulcers in the last two months. The trust was working with its commissioners to improve the quality of pressure care for patients in the community. This ensured patients needs were being met.

There were systems in place to monitor patient outcomes and the movement of patients through the care pathway. We were shown the Web V clinical portal. This was an electronic patient information board which included the National Early Warning Score (NEWS). NEWS is an early intervention tool to detect any deterioration in a patient's medical condition. The system also alerted staff to the patient's nutritional status, skin integrity, their mental capacity and falls risk. This ensured patient needs could be monitored regularly and early interventions started where required.
We observed on wards C1 and C2 nurses preparing all intra-venous (IV) medication behind the nurse's station. The area was cramped and noisy. This type of environment could lead to mistakes in preparing IV's and was not ideal from an infection prevention perspective. We discussed this with Board members. They recognised this was an area for improvement and said there were plans to reconfigure ward areas.

We looked at the ward environments to check if the trust was complying with the Department of Health same sex accommodation targets. We found the wards had systems in place to ensure patients of the same sex were accommodated in the bays. There were no breaches on the wards that we visited. This meant patients personal and cultural preferences were taken into account.

The maternity unit was responsive to women's needs. All women we spoke with said they felt safe and comfortable in the environment and had been treated by staff with dignity and respect. Women told us they were pleased the unit could accommodate partners overnight. Women and partners said they had been included in the birth plan and their wishes were valued. One woman told us, "They've (the staff) all been fantastic and I'm impressed with my treatment."

The unit used the Labour, Delivery, Recovery and Postnatal model of care. This meant the hospital stay was provided from a room which had en-suite facilities. Women were able to have their baby in the same room that they were admitted to, in a home-from-home environment. Women from out of the area were selecting to give birth at the hospital in order to use this model of care.

There was information for mothers about breastfeeding. The trust had achieved baby friendly accreditation level 1. The baby friendly initiative is a worldwide programme of the World Health Organisation. It encourages maternity hospitals to support women in breastfeeding. All midwives and health care support workers were trained in breastfeeding support. This ensured women who wished to breastfeed were supported.

We found high rates of normal deliveries, with low levels of interventions and caesarean sections. The unit had six Advanced Midwifery Practitioners (AMP's) who were trained to carry out advanced clinical procedures. The AMP's covered the unit 24 hours 7 days a week. This meant women could be seen in a more timely way and referred to the obstetric team if emergency interventions were required.

We discussed the management of high risk pregnancies. Data showed the trust was above the national average for stillbirths. The service had carried out various reviews but no specific care issues had been identified. Specialist midwives were in post across the trust who provided support and advice in areas such as safeguarding, substance misuse and teenage pregnancy. For those women who had certain pre-existing medical conditions, such as diabetes or epilepsy, there was a joint obstetric and medical clinic where a Consultant Obstetrician and physician were present to manage the care. This ensured women were monitored appropriately during their pregnancy.
Cooperating with other providers

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

Patient's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the trust worked in co-operation with others.

Reasons for our judgement

Patient's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the trust worked in co-operation with others such as commissioners, GPs, other trusts, ambulance services and community services.

At our last inspection we found due to the lack of beds in medical wards, patients were placed in other departments' wards. These patients are known as 'medical outliers.' During this inspection we found there were some patients who had been admitted to the stroke rehabilitation unit who had not suffered from a stroke. One patient said they had been moved three times before being admitted to the stroke ward. They told us, "It was about 9.45pm when I was moved, but everything was explained to me and the staff apologised. I was happy to move, and this ward is so quiet and peaceful."

We discussed medical outliers with the clinical lead who told us when beds were not available on the appropriate wards, patients would be admitted to a ward that closely met their medical and nursing needs. The trust had clear protocols in place to ensure the transfer of patients to other clinical settings did not impact on their length of stay or the patient's care and treatment. Whilst we had no evidence that the transfer of patients to other clinical settings had compromised the quality of care, this was not a good experience for patients.

We looked at the systems in place to ensure safe, timely and effective discharge of patients admitted to hospital. Information about discharge was provided to patients before admission and continued throughout the patients stay. Most patients said they had an idea when they were going to be discharged. They said doctors had explained what was happening and gave them time to ask questions. Records showed that discharge planning had started on admission and detailed the level of support required on discharge.

Where patients required additional community support or equipment aids appropriate referrals were made to other agencies and multi-disciplinary teams. This ensured there was community support to enable safe discharge. We spoke with two community
respiratory nurses who confirmed they worked closely with ward staff to support patients in the community. Respiratory patients were referred to the nurses for home assessment and to arrange support such as oxygen therapy, disease management and health promotion. The hospital also had access to discharge liaison nurses who were responsible for coordinating complex transfer and discharge of patients requiring social care or continuing healthcare. This ensured patients were provided with care in the right place.

The trust had plans in place to manage patient flow from entry into the hospital and through to discharge. We saw that ambulance handover times had improved significantly. There were arrangements in place between the hospital and ambulance service to ensure patients arriving in A&E were handed over to the clinical team within 15 minutes of arrival. A&E staff told us the average handover was 11-14 minutes. There were escalation processes in place for action to be taken if patients had not been handed over to A&E staff after 10 minutes. Two paramedics confirmed that handover times had improved. This ensured patients received clinical care without delay. National data showed the trust was achieving 98% of ambulance handovers to A&E staff within the acceptable target.

We found there were good working relationships between A&E and the Medical Assessment Unit (MAU) to ensure patients care was managed appropriately. There were regular ward rounds and senior doctor presence to accelerate patient transfer or early discharge. On MAU the trust had opened an ambulatory care ward. Staff told us the ward admitted patients with certain conditions which didn't require an overnight stay in hospital. This helped with patient flow and bed capacity. The ward was being piloted until the end of December 2013 to assess its effectiveness.

There was an out of hours GP service in A&E from 18.30 to midnight. At weekends and bank holidays GPs were on site from 8.00am to midnight. After midnight there was a GP on-call from home. Staff felt this had improved patient waiting times and relieved A&E staff to see more urgent cases. There was access to a range of services to facilitate an early discharge from A&E. For example, certain patients could be referred to a rapid assessment team which enabled access to physiotherapists and social care agencies. There was also good access to the mental health teams for support, advice and assessment of patients with mental health needs.

The Clinical Quality Indicators in November showed that A&E was achieving the national target of seeing 95% of all patients within four hours of attendance at A&E. However, this had dropped to 92.2% in the weeks prior to our visit. The lead A&E consultant told us there was a hospital wide plan to manage increased patient activity. We saw the trust had measures in place to manage winter pressures across the local health and social care community by ensuring escalation and communication networks across partner agencies.
Staffing

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<tr>
<th>There should be enough members of staff to keep people safe and meet their health and welfare needs</th>
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**Our judgement**

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet patient's needs.

**Reasons for our judgement**

There were enough qualified, skilled and experienced staff to meet patient's needs. The trust had management structures, systems and procedures which were followed, monitored and reviewed to enable the effective maintenance of staffing levels.

Most patients in A&E, the medical wards and maternity said there were sufficient numbers of staff to meet their needs. Patients in A&E said they did not have to wait long to be treated. One patient told us, "It's improved since last year, I've been seen quicker and everyone has been very considerate". Patients on the medical wards felt although staff were always busy their care needs were being met. One patient said it's been "first class." Three patients did say they thought there were not enough staff on at night. One patient told us, "The other night we got our bed time medicines at 1.15am and lights went out at 2am" and "We have even had tea time and bed time medicines at 8.30pm."

We discussed staffing levels in medicine with the matron. They told us the trust was continuing their recruitment drive to fill vacancies. They explained they had a proactive and planned approach for the use of agency staff to ensure staffing levels were maintained. They aimed to book the same agency staff to ensure patient's received consistency in their care. Where longer term staff absences were known a 'vacancy action plan' was completed to fill the post on a temporary basis. Most staff said one of their main concerns related to staffing levels. However, they recognised the trust was taking action to recruit additional staff. One staff member said it was a regular occurrence that they did not have enough staff on duty however a new shift system had been implemented which had improved staffing levels. The trust had also recruited two cohorts of Spanish nurses which had been well received in supporting staffing levels on the wards.

There had been improvements in staffing levels in A&E. Staff confirmed there was sufficient nursing cover for each shift. There were escalation processes in place to increase A&E staffing levels if required. The lead A&E consultant told us there was senior and junior medical staff cover which was also available out of hours. One of the doctors confirmed that the consultants would come in to provide cover when needed.

Midwifery staff raised some concerns about levels of staffing. They told us there was a shortage of midwives which included those working in the community. The service relied
on bank staff and staff picked up additional shifts when required. We spoke with the recently appointed Head of Midwifery. They told us seven newly qualified community midwives had been appointed and were currently receiving preceptorship support before starting work. This would ensure there were sufficient staff in the community to provide consistency of care to women.

We discussed medical staffing with the acting Medical Director and Associate Medical Director for Medicine. They said recruitment of doctors remained a major challenge for the trust. They told us there was a high usage of locums. There were recruitment drives taking place and six consultant posts had recently been advertised. We were told changes had been made to increase senior doctor presence at weekends and work was continuing to improve senior cover out of hours.

The Chief Nurse told us a review of nursing levels had been concluded. Immediate action had been taken relating to four wards where staffing levels and skill mix were identified as inadequate. This demonstrated the trust had responded to the needs of patients. Further work was being undertaken to review shift patterns and develop the care support worker role. The Chief Nurse indicated that nurse to patient staffing ratios were in line with nationally accepted guidelines.
Supporting workers  

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

Patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

During our previous inspection we found a large number of staff had not received mandatory training, appraisal or clinical supervision. Staff were inadequately engaged and staff morale was poor. At this inspection good progress had been made to improve these areas.

At this inspection 76% of staff across the trust had completed mandatory training against a target of 75% for the end of the year. A new Mandatory Training Information System was in place which enabled individuals to check the mandatory training requirements for their job role.

We found these improvements were reflected at ward level. In A&E mandatory training had improved from 20% to 78%. The new ward manager had introduced internal training to develop staff knowledge. A&E staff were very positive about the training and development programmes. Similarly staff on the medical and maternity wards told us they had received mandatory training and they felt supported to undertake further professional qualifications.

Nursing staff received corporate and ward induction before they started work. The programme included a skills and competency check. The trust had recently recruited qualified nurses from Spain who underwent a four week induction programme which included numeracy, language and a competency assessment.

Continued supervision and support was provided on the wards. There was appropriate arrangements in place for the supervision of midwives. They told us their supervisors were very good and they were always contactable if they had any concerns. Student midwives were well supported. Practice placement audits showed there were no concerns relating to mentoring. One student said, "I am made to feel a valuable part of the team." This ensured staff received appropriate support to enhance their professional development.

Information we had received from a recent Deanery visit showed that not all departments provided induction for junior and locum medical staff. The Deanery is a regional organisation which is responsible for postgraduate medical training. We spoke with the
Director of Organisational Development and Workforce who said there were processes in place to ensure doctors received corporate and local induction and their attendance was monitored. Feedback from doctors was used to review the induction programme. Locum doctors received local induction packs and went through an abridged induction process. We found there were some difficulties for juniors and locums to access IT logins and passwords and there was a lack of computers on some wards. The Director said this had been recognised and work was progressing to make improvements in this area. We spoke with medical staff in A&E. They felt junior doctors were well supported and they could approach senior staff to discuss clinical issues. There was regular teaching sessions for juniors in clinical areas.

We found progress had been made in ensuring staff received personal appraisal. The trust had re-launched appraisal documentation which had been disseminated trust wide. Information showed appraisals were linked to the trusts visions and values. On the wards we found most staff had received appraisals or had dates booked and plans were in place to achieve a 75% target by the end of the year.

Our visits to the wards showed improvements to staff morale. Most staff told us they felt supported and that the trust was promoting an 'open culture' for staff to raise concerns. One member of staff said, "I love my job, patients always come first, the care here is really good." Other staff told us changes to leadership had made a difference to staff morale. In A&E staff said there had been 'lots of changes for the better.' This was reflected in the comments received from patients who felt the staff 'knew what they were doing' and there appeared to be good staff interactions.

Most of the ward areas we visited were well managed. In a couple of areas we found where the ward manager was absent the management was less effective. We discussed this with the Chief Nurse. They told us job descriptions had been revised to ensure greater accountability of staff to lead ward areas. Leadership development had been identified for senior nurses and ward managers. A fourth cohort of staff would complete the programme by March 2014. This would ensure staff had the correct skills and support to deliver care and treatment appropriately.

The trust had introduced a number of initiatives to improve staff morale. This included reward and recognition for areas of good practice and clinical innovation. Staff engagement was encouraged by the trust. There were road shows which provided opportunities for staff to meet with the Chief Executive and make suggestions. Confidential and closed meetings were also provided for staff to attend and raise concerns. We looked at a staff morale survey from September 2013. This showed improvements in certain areas such as managerial working relationships, training and appraisal. Further work was noted in areas of communication, staff engagement and attitudes and behaviours.

Patients we spoke with were on the whole positive about staff. They said the staff were busy but that the care they received was, "First class" and "Five star treatment."
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that patients received.

Reasons for our judgement

NHS organisations are required to have a comprehensive programme of quality monitoring and improvement in place. Trusts refer to the process of quality assurance as 'clinical governance'. We looked at what systems the trust had in place to protect patients from the risks of receiving inappropriate or unsafe care and treatment.

The trust’s Board minutes showed that areas of risk within the trust were discussed as part of the executive board meetings and that challenge from non-executive members of the board occurred. A non-executive director (NED) explained there were board level champions for different areas of the board’s work. For example, NEDs chaired various Board Sub Committees, such as Quality and Patient Experience Committee and the Trust Governance and Assurance Committee. The committees met monthly and provided updates to the board about patient experience, complaints and incidents. This ensured there were assurances in place to inform the board of risks relating to the health, welfare and safety of patients.

Senior managers assessed and monitored the quality of the service through regular safety ‘walkabouts’ to wards where they observed care and spoke with patients and staff. Feedback from the visits was discussed with staff. Mock CQC inspections were also completed to test compliance against CQC regulations. This ensured there was senior management involvement in safety and quality.

We found the trust had systems in place to monitor and review incidents. The trust analysed patient safety data to get an understanding of the issues. There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example, following an investigation staff training had been identified in the clinical handover process for transferring patients from A&E to the ward.

There were systems in place to take action following never events. A never event is a serious, largely preventable patient safety incident that should not occur if preventable measures have been implemented. The trust had recently reported a never event which they were investigating. The trust had notified the Board and relevant organisations
including the CQC and the General Medical Council. The report and staff we spoke with showed systems had been reviewed and additional checking procedures put in place to reduce the risk of reoccurrence.

We looked at the clinical governance arrangements on the wards to assess whether there was staff engagement from board level and to determine if assurance processes were in place to monitor patient safety. There were appropriate clinical governance arrangements in place for the reporting and management of risk. There were clear processes for escalating risks to the trust board where required. Each directorate had their own governance meeting to discuss clinical quality, incidents and complaints to ensure action took place to improve any areas of concern. Senior managers and clinical directors received copies of directorate meetings and any adverse results were discussed at Board level.

The trust was in the process of strengthening clinical leadership and management structures to improve involvement of medical staff in clinical safety and mortality. The acting Medical Director told us there were systems in place to review mortality. Senior doctor and nurse reviews took place and concerns escalated to the executive team. Clinically led teams had been set up to focus on action to improve specific pathways of care, this included stroke and respiratory medicine. The trust told us there had been improvements in the management of these patients and mortality rates had improved. This ensured action was taken to improve clinical practice where required.

There was a programme in place for regular audits of care and treatment such as medicines management, infection prevention and control and quality of medical records. The trust was a member of the 'open and honest care: driving improvement' programme. The aim of the programme was for hospitals to be transparent in publishing patient safety data. The trust used the NHS Safety Thermometer. This was a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. In October 2013 the results against the four harms of pressure ulcers, falls, blood clots and urine infections for patients with a urinary catheter in place showed that 90% of patients did not experience any of the four harms in the trust. Staff told us the information helped them to identify areas of good practice and enabled them to respond quickly to concerns of clinical safety.

Patients, their representatives and staff were asked for their views about their care and treatment and they were acted on. The trust participated in national surveys. Results from inpatient, A&E and maternity surveys for 2012 -2013 which assessed a number of different aspects of patient experience (such as waiting lists, the hospital ward and doctors and nurses) showed the trust was 'about the same' or better than other trusts. We saw examples of patient questionnaires used in A&E. These showed suggestions had led to changes in infection control and mental health training for staff.

We looked at how maternity user’s views were considered. The trust in partnership with North and North East Lincolnshire Clinical Commissioning Groups took account of the views of women and their families through the Maternity Liaison Services Committee (MSLC). The MSLC was a multi-disciplinary forum which met four times a year and comments and experiences from women who used the service were used to improve standards of maternity care.

The use of patient stories had been introduced and shared with the Board and other trust groups. This allowed staff to gain a greater understanding of patient experience and ensure lessons were learnt and appropriate action taken to improve patient care.
The trust had a risk register which was used across ward, department and at corporate level to keep senior managers informed of the key risks in each area. The risk register showed risks relating to the delivery of care and the service were assessed. A risk had been identified for staffing and the trust had developed an action plan to improve staffing across the trust.

We looked at how the trust managed and reviewed complaints. Information about how to make a complaint was displayed in patient areas. Patients we spoke with were aware of the Patient Advice and Liaison Service (PALS). One patient said they had made a complaint via PALS and it was dealt with to their satisfaction. Another patient said, "My complaint was dealt with on the spot and I was happy with the outcome."

Information showed the trust had a backlog of complaints which had led to delays in investigating and responding to patients or relatives. This meant some complaints had been re-opened because people were not satisfied with the trust's response. The trust was reviewing its complaints procedures to improve the timeliness and quality of responses. This included recruiting additional experienced staff to respond to complaints.

The complaints manager explained learning from complaints was communicated to staff through newsletters and discussed with ward managers. Complaints and concerns were monitored by the Board. The trust offered a face-to-face meeting to people making complaints and involved clinicians to enable learning. We saw that reports included the action taken and lessons that had been learned from complaints. For example, changes had been made to the way pathology tests were requested. The trust recognised that it could still do more to ensure patients received timely responses to their concerns and that the whole organisation learnt from complaints.
Records

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

Patients were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

At our inspection in February 2013 we found not all clinical records were completed accurately to ensure patient needs were met in a timely way.

During this inspection we saw systems were in place to ensure patient records were accurate and fit for purpose. The records we looked at on the medical wards were completed appropriately in most cases. We looked at a random sample of maternity records and found there were some gaps in entries. Some midwives told us the notes were difficult to follow. There were some examples of junior doctors recording clinical procedures with no senior signatures to support their clinical interactions. Similarly student midwives had not had their entries countersigned by their named mentor. We discussed record keeping with the matron and staff who agreed the records required improvement in some cases and assured us they would action them.

The trust had a number of workstreams in place to improve the quality of patient records. They were in the process of introducing electronic patient records which would standardise documentation to ensure care was person centred and took account of patient's daily living needs. This would ensure safer standards of practice.

We found the Chief Nurse was proactive in ensuring improvements to record keeping were made. They carried out random walkabouts to review record keeping on the wards and regular audits. There was a quality matron who reviewed records and provided feedback issues to ward staff. This information was included in the nursing dashboard and senior nurses were responsible to follow-up areas of poor practice. A training programme was available for staff which identified the importance of good record keeping. This showed records were being reviewed to ensure appropriate information was held regarding patient care and treatment.

During our visits to the wards we observed records were securely stored to maintain patient confidentiality and appropriately transferred internally between departments and externally to other organisations when required.
We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

- **Met this standard**
  This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

- **Action needed**
  This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

- **Enforcement action taken**
  If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
**Glossary of terms we use in this report**

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.