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

**Facts and data about this trust**

**Acute hospital sites at the trust**

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

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham Hospital</td>
<td>101 Manthorpe Road, Grantham NG31 8DG</td>
<td>Urgent &amp; Emergency Services, Surgery, Medicine, Diagnostics, Children, Inpatient, Maternity</td>
<td>Lincolnshire</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Greetwell Road, Lincoln, LN2 5QY</td>
<td>Urgent &amp; Emergency Services, Surgery, Medicine, Diagnostics, Children, Inpatient, Maternity</td>
<td>Lincolnshire</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>High Holme Rd, High Holme Road, Lincs LN11 OEU</td>
<td>Medicine, Surgery, Children, Diagnostics</td>
<td>Lincolnshire</td>
</tr>
<tr>
<td>Pilgrim Hospital Boston</td>
<td>Sibsey Road, Boston PE21 9QS,</td>
<td>Urgent &amp; Emergency Services, Surgery, Medicine, Diagnostics, Children, Inpatient, Maternity</td>
<td>Lincolnshire</td>
</tr>
</tbody>
</table>
Background to the trust

The United Lincolnshire Hospitals NHS Trust (ULHT) was formed by the merger of three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country providing a range of services through three main hospitals (Pilgrim, Lincoln County and Grantham District) with some medical and surgical (Louth).

Lincolnshire is a largely rural area; the trust provides a range of hospital-based services to the 750,000 people of Lincolnshire with 1,213 inpatient and 231 day-case beds across 51 wards.

Facts and data about the trust

Lincolnshire is the second largest county in the UK and is characterised by dispersed centres of population in large towns and the city of Lincoln, and otherwise largely rural communities.

Transport networks are underdeveloped resulting in transport times of around one hour between the respective hospital sites.

Lincolnshire has one of the fastest growing populations in England projected to rise to 838,200 by 2033.

The trust provides acute hospital care, to around 757,000 residents of Lincolnshire.

Indicated levels of health care need are relatively high due to an accelerating population (above the national average) and the trend towards an ageing population profile will continue, with the proportion of people over 75 years of age predicted to increase by 101% between 2012 and 2037. These factors combine to increase pressure on hospital services, particularly urgent care (COPD, diabetes, CHD, and elderly frailty) and referral for cancer treatment, and it is widely acknowledged and understood that the way health and care services in the county are provided needs to change.

The trust has 1,213 general and acute inpatient beds and 231 day-case beds across 51 wards, operates 1155 outpatient clinics per week and employs approximately 14,972 staff. It is one of the largest acute NHS trusts in England.

The trust provides a full range of acute clinical services across 18 CQC registered locations. Most of acute clinical services run from three main hospital sites, Lincoln County Hospital, Pilgrim Hospital and Grantham Hospital.

The Lincoln and Pilgrim Hospitals provide a full range of clinical services, with only the following exclusions:

- Neurosurgery
- Cardiothoracic surgery
- Spinal surgery

Specialised services are provided at ULHT either at Pilgrim Hospital or at Lincoln Hospital, and in the case of some services, both hospital sites. The specialised services include: critical care level three and stroke medicine at Pilgrim and Lincoln Hospitals, cardiology (Cardiac Centre at Lincoln), specialised rehabilitation medicine level 2a at Lincoln and vascular services at Pilgrim Hospital.

Grantham & District Hospital does not provide any in patient specialised services; there is currently a restricted medical take at Grantham, together with a range of elective surgery and outpatient services. Grantham hosts the Trust’s main cardiac diagnostic services, including cardiac MRI and cardiac echo.
Patient numbers

Each year the trust sees within the region of

- 998,659 outpatient attendances
- 133,029 inpatient admissions
- 34,202 planned elective surgical cases
- 150,935 attendances at the accident and emergency department
- 5,026 babies born

(Source: Hospital Episodes Statistics October 2016 – September 2017)

Financial position

For the financial year 2017/2018, the trust income was £427,493 million. There was a deficit (shortfall) over costs incurred of £82,400 million, which was £5.4m greater than the revised control total of £77 m agreed with NHSI in December 2017. The £77m was exclusive of a number risks notified to NHSI and deemed to be outside of the control of the Trust that are now part of the forecast and total £4.3m. The balance of £1.1m is deemed to be in the Trust’s ability to manage, and further savings opportunities have been put in place to mitigate this where possible and safe. The Trust has an ambition to deliver £30m of efficiencies in 2018/19 and was working to identify and implement additional schemes to increase the already identified £19.7m. Failure to deliver the control total had resulted in lost sustainability and transformation funding (£14.7m) and additional cash support for revenue costs.

At the time of our inspection the trust was in financial special measures. Trusts are put into special measures for financial reasons to achieve accelerated financial recovery and improve financial governance. The special measures approach consists of rapid planning and delivery of accelerated recovery activities, through greater control by NHS Improvement.

What people who use the trust’s services say

In the six months from October 2017 to March 2018, the trust’s NHS Friends and Family Test results (percentage of patients who would recommend the hospital) was similar to the England average. In the most recent month to be published when this report was written (March 2018), 87% of patients said they would recommend the trust.

In the Cancer Patient Experience Survey 2016, the trust scored significantly badly in the survey with 25 out of 52 questions scoring significantly below the national average and none significantly above the national average. This survey looked at the experiences of 740 cancer patients who received treatment at ULHT in April, May or June 2016.

Inpatient Survey 2016

In the 2016 inpatient survey the trust scored as expected for all questions except for one question which was ‘during your hospital stay, were you ever asked to give your views on the quality of your care?’ In this question the trust scored 2.1 which was worse than other trusts.

Patient experience declined in four areas in the 2016 survey compared to the 2015 survey. The areas that declined were:

- Enough nurses on duty to provide care
- Written instructions provided for after leaving hospital
- Told who to contact if worried about condition or treatment
- Time between arrival and getting a bed on a ward
At Grantham and District Hospital the majority of results were as expected. There were two questions that were better than expected (enough privacy when being examined in A&E and staff doing everything they could to control pain) and one question was worse than expected (being told about danger signs to look out for).

At Lincoln County Hospital the majority of results were as expected. There was one question that was worse than expected (asked to give views on quality of care).

At Pilgrim Hospital the majority of results were as expected. There were two questions that were worse than expected – (written instructions provided for after leaving hospital and told who to contact if worried about condition or treatment).

In the CQC children and young people survey 2016 (patients who received inpatient or day case care during October, November and December 2016). The trust was about the same as expected for all measures except for children aged 8-15 feeling they had enough privacy during their care and treatment, for which the trust was better than expected. Responses were received from 294 children and young people.

**Maternity Survey**

United Lincolnshire Hospitals NHS Trust scored about the same as other trusts for all questions in the 2017 maternity survey.

There were two questions where the trust had previously scored better than other trusts in the 2015 maternity survey but the score had deteriorated to score about the same as other trusts. These were:

- At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital? 2017 score: 8.6; 2015 score: 9.3
- Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted? 2017 score: 6.8; 2015 score: 8.2

The trust’s score deteriorated in 14 out of 19 questions in the 2017 maternity survey. The questions with the highest deterioration were:

- If you raised a concern during labour and birth, did you feel that it was taken seriously? 2017 score: 7.5; 2015 score: 8.8.
- Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted? 2017 score: 6.8; 2015 score: 8.2.

The trust’s score improved in two out of 19 questions in the 2017 survey:

- Did the staff treating and examining you introduce themselves? 2017 score: 9.3; 2015 score: 8.9.
• 6 Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted? 2017 score: 8.9; 2016 score: 3.1

There were two questions where there was no change in the score between 2015 and 2017 and one question that did not appear in the 2015 survey (this was related to discharge being delayed).

In the Patient-Led Assessments of the Care Environment (PLACE) 2017 the trust was below average on all measures except food, but the differences were not significant. All measures improved from 2016 to 2017 (except the privacy score which was essentially unchanged) with the food, disability and facilities scores rising fastest. At site-level there were mixed results. All four sites were below the acute trust average for all measures except food (all sites) and facilities (Pilgrim Hospital only). Pilgrim Hospital had the best overall results among the ULHT sites.

Is this organisation well-led?

Leadership

To write this well-led report, and rate the organisation, we interviewed the members of the board, both the executive and non-executive directors, and a range of senior staff across the hospital. This included a wide group of clinical and non-clinical service and specialty directors. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans; board meeting minutes and papers to the board, investigations, and feedback from patients, local people and stakeholders.

The executive directors had the skills, knowledge, experience and integrity to lead the trust with some changes to personnel and roles taking place since our last inspection (October 2016). Ongoing improvements were a continued focus for the executive team. However, we found there was a lack of capacity amongst the executive directors. Executive team members faced significant challenges because they were drawn into operational difficulties within the organisation. The breadth of significant operational, quality, financial, workforce and safety issues that require urgent improvement at the trust limit the capacity of the executive team to sustainably address these issues at pace. Leaders at different levels told us they were consumed by operational issues as opposed to being able to step back and work on the strategic issues in the organisation. This was hampering the ability to work at pace with regards to quality improvement. We did however see how significant development had been carried out with leaders in the organisation to help free up capacity of the executive directors.

The trust board comprised of 11 voting members a chair, five Non-Executive Directors (NEDs) and eight executive directors. A newly appointed interim chair had taken up post in January 2018 this was expected to address concerns regarding board effectiveness.

There had been significant improvement in the stability of the executive board in 2017/18. After a period of prolonged executive turnover and interims, all executive posts were now substantively filled. The chief executive had been in post since 2015 and director of nursing since 2016. The medical director was appointed in 2017, although had previously worked as the trust deputy medical director.

Prior to the interim chair taking up post there had been seven NEDs at the trust as determined by the establishment order, however the interim chair had decided in order to operate as a unitary board the trust would work with a cohort of five NED’s and carry two vacancies. This balanced the number of voting members of executives and non-executives and was intended to better reflect
democratic principles and good governance. It also enabled a future chair to make their own judgement on what was required and to recruit accordingly.

The NEDs had joined the trust at a variety of dates from 2010 to 2018. The NEDs had a range of experience including business; public, healthcare and private sector. We held a focus group for the NEDs and, three attended. The NEDs had a clear understanding of their roles and the remit and accountability, including addressing the challenges for the trust, of the governance or performance committees they chaired. Driving improvements throughout the trust was a clear focus

**Board Members**

Of the executive board members at the trust, there were no British Minority Ethnic (BME) members and 25.0% were female.

Of the non-executive board members 14.3% were BME and 71.4% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>14.3%</td>
<td>71.4%</td>
</tr>
<tr>
<td>All board members</td>
<td>6.7%</td>
<td>46.7%</td>
</tr>
</tbody>
</table>

(Source: *Routine Provider Information Request (RPIR) – Board Diversity tab*)

The director of nursing had two deputies and a corporate head of nursing all of whom worked across professional standards. In addition, there were five quality matrons who were relatively new in post, their remit was to focus on delivering improvements in patient safety and quality assurance, this protected them from working to support the operational pressures within the trust.

The medical director had two associate medical directors. One led on professional standards and one on mortality. The medical director worked clinically one day per week (one clinic and one operating list). This allowed him to be familiar with the systems and problems facing his colleagues.

Prior to our inspection we attended two board meetings, at both board meetings we could see the influence the NEDs had on the overall leadership of the trust, we saw an appropriate level of challenge from NEDs at board meetings. NEDs told us they felt they had the right balance between support and challenge and had never had any resistance from the executive team in relation to challenge. We were told that executive directors welcomed the challenge however some executive directors told us they thought there could be more challenge. We saw that there had been an increase in the challenge NEDs provided since the appointment of the interim chair.

Board meeting minutes we reviewed showed there were records of discussions and challenges about performance, accountability and confirmation of the actions agreed, but this did not always capture the full discussions. Some NEDs told us that there wasn’t always quality or speed in agreed actions and that action plans were seen as the end of the process.

We saw and were told that there was a lack of challenge amongst the executive directors, for example we heard that financial performance was not challenged as much as it could be and the director of finance had to ask for challenge from the board. Whilst executive directors were supportive of each other outside of the boardroom, we were told and saw that there was little
support for each other within the board room, for example they did not engage in discussions to support each other when being challenged.

The trust leadership team had knowledge of current priorities and challenges and was taking some actions to address them. Although the leadership team had oversight of most of the challenges that the organisation faced, we raised issues that had been found on the core service inspection they were unaware of or their oversight was insufficient. For example, concerns in relation to the emergency department and children and young people services at Pilgrim Hospital. When we pointed the issues out the trust responded urgently with clear and detailed action plans to address these concerns. Whilst the trust was still reactive at times we saw positive signs of a more proactive response emerging. We heard from most executives and non-executives that you “don’t know what you don’t know.” There had been improvements in the way the trust responded to risks since our October 2016 inspection when we found a lack of urgency and ownership to address some key risks that we had raised.

The trust was split into 15 directorates and had a management structure in place with lines of responsibility and accountability, these were not always effective. The complex directorate structure made implementation of board decisions difficult. Triumvirate leadership for each directorate was provided by a clinical director, general manager and head of nursing. Each speciality had a head of service who reported to the clinical director. Local leadership at ward/unit level was provided by matrons and ward managers. Each directorate was accountable to the chief operating officer. We noted in some directorates, leaders didn’t not have the capacity or capability to lead services. The executive team were in the process of reviewing capacity and capability of the leaders within the directorates to ensure all leaders had the appropriate range of skills, knowledge and experience to lead, they were providing additional support to those who required it.

At the time of our inspection the trust had gone out to consultation with regards to plans to reconfigure and reduce the number of directorates. They had recognised that there needed to be stronger clinical leadership and accountability at this level. The consultation was to be completed by the summer with the aspiration to implement the changes prior to winter.

The trust had a senior leadership forum on a bi-monthly basis for all senior leaders to work collectively on significant issues facing the organisation. Staff we spoke with found this meeting useful.

To address challenges to quality, the trust leadership team commissioned external reviews both where it was required to do so, but also when it recognised the need to take this step. We saw many examples of when this had been the case for example we saw a review of the trust governance arrangements had taken place following our last inspection and the trust had requested a neighbouring trust review their diabetic services.

There was a programme of board visits to services/ward, and most staff we spoke with welcomed these. Staff told us of board to floor visits by the executive team and non-executive directors. Information from these visits were linked into the quality governance committee meeting for further assurance, follow up and contemporaneous understanding of their issues and progress.

The board were viewed as accessible, approachable and visible. Staff were complimentary on the visibility of the director of nursing and the chief executive. Nursing staff felt that the director of nursing was a strong advocate for nursing. Medical staff told us they found the medical director supportive and approachable, although not as visible across some sites as they would like. They did however tell us that they could access him and had direct access to him should they have issues to discuss. Emergency department (ED) staff described the chief operating officer as accessible always and had found him supportive with the ED challenges.
We carried out checks to determine whether appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. A fit and proper person (FPPR) procedure was in place. We reviewed the personal files of two executive directors and two non-executive directors to determine the necessary fit and proper person checks had been undertaken. We found that all checks had been completed and the trust was fully compliant with FPPR requirements. This represented a significant improvement from the October 2016 inspection.

The trust has had in place a suite of leadership development programmes for staff at all levels and was a member of East Midlands Leadership Academy which gave staff free access to all programmes. In January 2017 the trust implemented a mandatory two-day management programme to ensure that leaders were delivering their role consistently and in line with the trust's vision and values.

The trust had undertaken a critical review of all leadership development programmes to allow for a thorough re-development of programmes to ensure that they were fit for purpose, support national initiatives and linked to trust objectives and performance management. The new programme was competency based linked to the requirements of the role and individuals' current competency.

During 2016/2017: 41 people attended the six-day leadership in practice programme for Bands 6/7. The Stepping up to Management programme for Bands 4/5 six-day course was attended by 53 people. The senior leadership development programme was attended by 32 people. During 2017/2018, 201 attended the trust two day “supporting you to manage and deliver our values and behaviours” programmes.

The trust did not have a talent and leadership management strategy. A people strategy was in place and a clear approach to leadership and management development was included within this. There was a ‘talent academy’ which developed staff at all levels and there were a range of talent initiatives including one trailblazer programme. The trust had developed a new approach to individual performance management which set out the approach to leadership and talent management for 2018/2019. This would ensure that development opportunities were fairly and transparently targeted. The performance management processes redesign had commenced with appraisals starting with senior executives in April and May to begin the golden thread of performance from the business plan. The strategy referenced performance management as a process that defines accountability boundaries and which enables staff to be productive. The strategy referenced learning but lacked ambition about what that means for staff.

Regular board thinking days and development days took place to ensure that skills were developed. Some board thinking days were externally facilitated.

The learning disability team was from a neighbouring trust. There were no service leads for both child and adolescent mental health (CAMHS) or autism; however, the trust worked closely with a neighbouring NHS mental health trust with regards to CAMHS and autism. The deputy chief nurse led of mental health within the trust the director of nursing was the board member responsible for mental health and learning disabilities.

**Vision and strategy**

The trust had a clear vision and set of values with quality and sustainability as the top priority. The trust had aligned its strategy to local plans in the wider and health and social care economy. The trust was actively involved in the sustainability and transformation plans (STP). The 2021 programme incorporated elements of the STP relevant to trust. Plans were being developed to implement the strategy, but in the short term, the trust had competing priorities and urgent improvement requirements which were complex.
The trust vision was to:

- Improve our quality and performance of care in line with national standards.
- Reflect wider NHS national agendas for new ways of working.
- Treat fewer people in our hospitals, being more effective and efficient.
- Develop new and innovative models of care.
- Attract more Lincolnshire patients to choose ULHT for their planned care.
- Consolidate services onto specific sites and develop centres of excellence. Becoming a national, if not an international, centre for rural healthcare.
- Change and shape of our workforce in line with the new models of care.
- Work in partnership to sell Lincolnshire as an excellent place to live and work.

The trust values were:

- Patient centred.
- Safety.
- Excellence.
- Compassion.
- Respect.

To ensure the values and vision were embedded the trust had launched a staff charter and personal responsibility framework this would support the delivery of the vision, values and ambitions.

The charter set out clear expectations of ‘what we expect to see from staff’ and what ‘staff can expect from the trust as an employer, describing how together they would deliver excellence in rural healthcare for all patients.

During our core service inspection, most staff knew of and could articulate the values. Across most services we saw staff delivering care in line with the trust values.

In November 2017 the trust identified the new vision, "Excellence in Rural Healthcare".

The strategy aimed to be delivered through three ambitions which set out the intended future outcomes to strive for excellence:

- Our Patients: Providing consistently safe, responsive, high quality care.
- Our Services: Providing efficient, effective and financially sustainable services.
- Our People: Providing services by staff who demonstrate our values and behaviours.

These ambitions set out the intentions for remaining clinically, operationally and financially sustainable. The ambitions had objectives and key measures to performance manage their delivery.

The 2021 strategy had two key parts - "Striving for Excellence", which sets the strategic direction with the ambitions and the key enabling strategies, and the "Delivering Excellence" part which set out the improvement programmes. These were both underpinned by the values and the behaviours further supported through the staff charter.
The 2021 strategy was clear and there appears to be a robust channel for defining what it is ULHT wanted to achieve, and the pathway for achieving it. There was consultation through ‘big conversations’ internally so that staff could feed in their thoughts on the strategy, and through patient groups / focus groups to engage externally. About 3000 people were involved in total. The internal consultation was assessed as being successful as staff had taken the opportunity to reshape some of the objectives and focus of the strategy, because they felt the original draft lacked ambition. The strategy document has since been reshaped based on staff feedback. It was acknowledgement by some executive directors that it was difficult to gain internal buy-in or support for ‘big conversation’ style events. Such events are used to showcase the work undertaken to-date and to receive feedback on the work that has been shaped. Therefore, the consultation isn’t ‘bottom-up’ in the trust sense, which may explain why staff in the recent survey feel a declining sense of engagement in the strategy and vision.

With regards to delivery of the strategy, there were clear processes and governance in place to oversee the work. An integrated performance report was taken to that committee including regular items at the Board. Processes were in place to assess the work of the HR team at a senior level. There was a culture of looking up towards the committees and governance to provide reassurance that they are delivering the right things for staff.

Whilst most staff were aware of the vision and strategy for the trust, some staff told us that it was a long document to read. Some staff told us they had met with the programme board and had suggested that there was a one-page strategy document created for ease of understanding. The programme board were looking to create this at the time of our inspection.

Staff within the trust developed a comprehensive mental health and learning disability transformation plan / strategy in conjunction with the local mental health trust. Mental health (MH) policies and procedures included clear decision-making flowcharts in line with the Mental Health Act code of Practice (MHA). The MH strategy group incorporated staff from both the acute and mental health trust. There had been significant improvements in the knowledge and management of patients presenting to the trust living with dementia or a mental health condition since our last inspection.

The business plan for pharmacy clearly outlined the actions required to achieve the Carter recommendations and meet the Model Hospital benchmarks. Included within these actions was the need to implement electronic prescribing. A business plan for this had been submitted and this was initially unsuccessful. A further bid had been resubmitted for capital funding and a multidisciplinary project management group had been established.

The Trust was working with other local health economy stakeholders through the acute services review, which is an assessment of the structure of services across the trust’s sites, with an intention to improve the sustainability of the care it delivers. The acute services review set out a number of strategic options for consideration by stakeholders. These options largely promoted increasing use of hub and spoke models across the trust’s sites and centralisation of some services at single sites. It was anticipated these would improve both patient and financial outcomes for the trust and local health economy. A decision had not been made at the time of our inspection by stakeholders on which options it will pursue.

The trust maintained an open dialogue with its regulators on the structural challenges it faces. It had communicated clearly the significant financial cost, and challenge to sustainability it faces from operating hospitals in areas of low population. It also struggled to recruit substantively to these rural areas which presented a structural challenge to sustainability.
The trust had significant performance, quality and safety, workforce and financial issues which require improvement action at pace. Improvement plans were subject to significant challenge, oversight and scrutiny from NHS regulators, commissioners and health bodies.

The Trust had significant workforce issues which result in high cost temporary solutions which were unaffordable and unsustainable. The trust had acted to identify workforce priorities and was reviewing its establishment. The Trust did not deliver its agency ceiling of £21m in 2016/17 and the ceiling will be breached in 2017/18. To date, limited improvements have been made to address temporary staff spend due to significant recruitment and vacancy issues.

Culture

The Trust faced considerable challenge in embedding and sustaining a culture of high quality sustainable care due to its geographic spread (multiple sites), reliance on temporary staff, complex organisational structure and focus on addressing immediate operational issues. However; most staff in the trust articulated and demonstrated the values of the organisation and reported feeling supported, respected and valued. The culture amongst staff at this inspection had generally improved since our last inspection, staff appeared more engaged. The development of the staff charter was seen to be a lever in staff engagement and improvement in culture. Staff were positive about this charter. The charter set out clear expectations of ‘what we expect to see from staff’ and what ‘staff can expect from the trust as an employer, describing how together they would deliver excellence in rural healthcare for all patients.

The Trust has looked outside the organisation to learn from best practice and had adopted the System 1 and System 2 cultural change approach. This focused on both systems and processes and hearts and minds.

Following the publication of our last inspection report in April 2017, the trust was placed into quality special measures. Following this with the support of an NHS Improvement Director, the trust developed a quality and safety improvement plan. Its focus was to develop a culture of safety whilst making improvements in quality, in line with the trust’s quality strategy and the findings of the CQC inspection. The plan identified 17 key areas, each with specific milestones. The trust had significantly improved performance around safety within the last 12 months. Many of the milestones identified with the 17 areas had been completed and resulted in improvements to some patient outcomes and the quality of care such as sepsis, airway management and control of infection.

The trust had implemented a number of measures which had improved the incident reporting culture. They believed they were operating much safer services but recognised they still had improvements to be made in the coming year. There appeared to be a stronger safety narrative within the organisation, and all staff we spoke with described their responsibilities in relation to safety culture the launch of the staff charter would further support and embed this culture.

United Lincolnshire Hospitals NHS Trust was a regular reporter to the National Reporting Learning System (NRLS) and did not take significantly longer than other trusts to report patient safety incidents. The trust reported fewer incidents than average, but the difference was not significant, and there had been improvement in reporting. The number of incidents reported by ULHT between September 2016 and August 2017 was 92% of the level we would expect based on activity at the trust and national reporting rates, up from 79% of the expected number in the previous year.
In the year from October 2016 to September 2017 there were roughly 1,000 patient safety incidents per month that were reported to NRLS, a 13% increase when compared to the previous 12 months. In particular, infection control incidents almost doubled (from 189 to 346). Many of the extra infection control incidents were patients who had not been screened for sepsis. The increase is seen as positive, as signs of strong reporting culture and an increased focus on sepsis screening which was raised as an issue with the trust at the October 2016 inspection.

The trust had done a lot of work with regards to holding people to account. Staff were expected to follow trust policies and procedures and conform with the trust values. Staff were held to account for not doing so, this had led to an improvement in the culture and empowered staff to professionally challenge each other. Matrons and ward managers described the process as being difficult at first, as staff often perceived this was bullying, however they had worked hard to drive down this barrier to ensure staff understood what being held to account meant. Medical staff described being held to account for their performance and behaviour and we were given one example which related to the compliance with the safety checklist in theatres. This had considerably improved as a result.

Staff culture in the organisation was mixed and varied across the different hospital sites. Staff reflected that there was a difference in culture between the hospital sites. Some staff acknowledged that this was due to the different needs and demands of the local populations. However, other staff told us they didn’t feel fully integrated as one trust; this could cause some differences in attitudes and practice. During our core service inspections staff referred to themselves as working at “Pilgrim” “Lincoln” or “Grantham” rather than seeing themselves working at United Lincolnshire Hospitals. Some staff described the trust as not “united”. Consultants told us there were often difficulties understanding how things worked at different sites and said there was not a cohesive policy of how they worked together with other sites. Senior leaders had recognised the challenges and plans were in place to rotate staff across sites. Some directorates were “pan trust” whilst others were site based. As part of the restructure more services would be managed “pan trust”. Matrons described working more “pan trust” and said this had been a positive experience, especially understanding the challenges of different sites. We saw how some local leaders had been seconded to different sites to help with integration. The restructure of clinical directorates would enable staff to work more across site.

Clinical directors and heads of nursing told us that they felt there was a positive culture within the trust and that the executive team were supportive. We were told that there were co-operative and supportive relationships amongst most directorates and they mostly worked collaboratively together.

Some consultants told us there were gaps in communication lines. They often didn’t get chance to put their views up to management (executive) level. They did however tell us that the chief executive had recently started a team brief for clinical directors to cascade down. Consultants in Medicine at Grantham felt their voices weren’t heard, they felt this was a result of not having a clinical director for medicine.

At our last inspection there were low numbers of consultants who had job plans. This had considerably improved at this inspection and 95% of consultants had job plans. We were told by clinical directors that there was a strong focus on ensuring new recruits had job plans and there was oversight and management of job plans.

To increase nurse recruitments, the trust had taken a “cohort” approach. During our core service inspections, local leaders said that they did not have control over this process and were often not
involved in the recruitment process for their area. This had led to some nurses struggling in the ward area or ward areas without the sufficient expertise. The "cohort" process had also negatively affected morale amongst teams.

Due to the number in nurse vacancies, nursing staff across the wards were often moved to cover other clinical areas. During our core service inspections, we received a consistent message from nursing staff that this was negatively affecting morale. They did however recognise why this needed to be done.

Staff described a no blame culture and how they were encouraged to report incidents. They did however say it was time consuming when already under pressure and often didn't report low level incidents.

Staff mostly described being listened too but they did not feel that they always got a solution to their issues.

Most nursing staff described the director of nursing has having an open-door policy and would not hesitate to approach her. Band 7 leaders described the weekly meeting with the director of nursing as “having their voice heard”. They told us the director of nursing would “listen and respond”.

From discussions with staff and the senior pharmacy team it was clear that they were under pressure and there was a significant focus on flow through the trust. We heard that the senior pharmacy team had taken steps to engage with the pharmacy team. For example, staff had been involved in workshops to gain their views and ideas on implementing the HPTP agenda but not all staff were doing so. It was not clear whether this was a result of poor communication or reticence. The business plan recognised that lack of staff engagement was a risk factor for success. Senior leaders in the pharmacy told us that they had accessed support from HR in managing a challenging team where there were pockets of significant resistance to change. Some pharmacy staff told us that there was little opportunity for professional development within the trust, however, we saw that there was a higher than average number of pharmacist Independent Prescribers allowing for some career progression and development.

During our inspection we held a number of focus groups across most hospital sites with staff. These included consultants, nurses, allied health professionals, heads of nursing, clinical directors and support staff. Most focus groups had little attendance and we were told this was due to the challenges in staffing and workload in the clinical areas. We planned a focus group black and minority ethnic (BME) staff but, no one attended. No-one from the pharmacy team attended the initial pharmacy focus groups for this inspection and we identified that this was because none of the team were aware it had been offered. This may be indicative of poor communication lines within the trust involving the pharmacy team, we arranged a further focus group which was well attended.

A Freedom to Speak up Guardian (FTSUG), took up post in October 2016. Freedoms to speak-up guardians were introduced following Sir Robert Francis’s Freedom to Speak-up Review (2015). Their role is to work with leadership teams to create a culture where people are able to speak-up to protect patient safety. The trust freedom to speak up guardian was also the company secretary and we did not see they had dedicated time to the role, it was in addition to the current role. The FTSUG had done work across the trust to improve their visibility this included visiting clinical areas across all sites, posters and a dedicated intranet page. During our focus groups with various staff groups and during our inspection of core services, very few staff knew of the FTSUG role or knew who the FTSUG was. The trust told us they were continuing to focus on improving awareness of the FTSUG role. The trust was looking to expand this by adding FTSU champions in different staff groups. The FTSUG had engaged with members of the LGBT staff network group and the BAME
staff network group. Members of these groups were keen to support the FTSUG work. We asked the FTSUG of any themes from concerns that had been raised with them, they told us there was no themes but felt staff working in pressurised environments ‘did not bring out peoples’ best behaviour’.

The National Guardian’s Office asked Freedom to Speak Up Guardians in all trusts and foundation trusts for information on Freedom to Speak Up cases raised with them in the third quarter of 2017/18 (1 October - 31 December). The latest results for ULHT were:

<table>
<thead>
<tr>
<th>Number of cases raised</th>
<th>Raised anonymously</th>
<th>Element of patient safety/quality</th>
<th>Element of bullying/harassment</th>
<th>Suffering detriment</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

The trust had 25 cases referred to the FTSUG between March 2017 to March 2018. The trust could not provide a comparison as it didn’t previously collect this data. The subject of the cases had covered behaviours and bullying, patient safety and working conditions.

Between October 2017 and March 2018, the CQC received 12 whistle-blower concerns. Themes included, staff concerns around the trust culture and local managers response to concerns; time available for staff to attend to patient’s basic needs; the suitability of patients for some wards and concerns around services provided at Grantham Hospital.

The trust had three guardian of safe working (GOSW). The GOSW had been introduced to protect patients and doctors by making sure doctors aren’t working unsafe hours. The GOSW met with the CDs and business manager where a trend in concerns reported by junior doctors. We were told common themes were misunderstandings and miscommunication between junior doctors and consultants, and junior doctors being asked to cover on call and therefore missing learning opportunities. The Guardian is required to produce a quarterly and an annual report to the Board to provide reassurance that trainees are working safely under the new contract and highlighting any safety issues, if necessary. There had been no reports to the board.

A bi monthly junior doctor forum had been set up for Drs to raise any concerns. The GOSW were in the process of setting up a web form to allow greater access for doctors to raise concerns.

The October 2016 inspection led to an action for the trust to make sure staff were up-to-date with mandatory training. As of March 2018, core learning compliance for mandatory training (trust wide) was 89%. This was below the trust target of 95%.

The trust’s operated an appraisal system to support staff development, not all staff were having appraisals when they were due, however there had been an improvement. As of end of March 2018, 97% of eligible medical staff were appraised. This was above the 95% target set by the trust. However, for non-medical staff was 80% below the trust target of 85%. This meant a significant number of non-medical staff had not had the opportunity to discuss their developmental needs. Some staff told us appraisals were a “paper exercise” and they rarely found them meaningful. We were aware that the trust had launched a new individual performance management process at the time of our inspection (April 2018).

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires
providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. The trust had a duty of candour policy, when we reviewed and found to be out of date since January 2018. Most staff were aware of their responsibility to be open, transparent, and honest and gave examples of when they had offered patients and relatives an apology. Most senior staff were aware of the trust’s policy and their requirement to apply duty of candour for any incident that was investigated and categorised as moderate or above and knew the thresholds for when Duty of Candour processes were triggered. Despite staff demonstrating awareness of the processes to follow we found the trust was not fully compliant with the duty of candour. Trust wide data as of February 2018 showed that verbal compliance when duty of candour was required was 61% and for written duty of candour 16%. The local CCG had set the trust a target of 95% and had told the trust it must improve by June 2018. A list of duty of candour incidents was sent to each directorate monthly. The trust attributed a lack of staff taking ownership to write duty of candour letters as one of the contributing factors to poor compliance, written letters not being attached to the incident management system so no evidence it has been done. Following the conclusion of an incident there was no system in place to confirm that the letter was sent to the patient or their next of kin. The trust recognised it had further work to do and were in the process of creating an e-learning module for all staff to complete on duty of candour. They were also in the process of developing a leaflet to raise awareness in clinical areas.

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

The trust had three key findings that exceeded the average for acute trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF20. % experiencing discrimination at work in last 12 Months</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2%*</td>
<td>2%</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>68%</td>
<td>66%</td>
</tr>
</tbody>
</table>

*Note that the trust score appears to be the same as the national average due to rounding of numbers.

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

The trust had 25 key findings worse than the average for acute trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF12. Quality of appraisals</td>
<td>2.96</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or Development</td>
<td>3.97</td>
<td>4.05</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.50</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.49</td>
<td>3.65</td>
</tr>
<tr>
<td>KF</td>
<td>Description</td>
<td>Score 1</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>KF18</td>
<td>% attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>56%</td>
</tr>
<tr>
<td>KF19</td>
<td>Org and management interest in and action on health and wellbeing</td>
<td>3.34</td>
</tr>
<tr>
<td>KF15</td>
<td>% satisfied with the opportunities for flexible working patterns</td>
<td>45%</td>
</tr>
<tr>
<td>KF1</td>
<td>Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.43</td>
</tr>
<tr>
<td>KF7</td>
<td>% able to contribute towards improvements at Work</td>
<td>65%</td>
</tr>
<tr>
<td>KF8</td>
<td>Staff satisfaction with level of responsibility and Involvement</td>
<td>3.82</td>
</tr>
<tr>
<td>KF9</td>
<td>Effective team working</td>
<td>3.61</td>
</tr>
<tr>
<td>KF14</td>
<td>Staff satisfaction with resourcing and support</td>
<td>3.17</td>
</tr>
<tr>
<td>KF5</td>
<td>Recognition and value of staff by managers and the organisation</td>
<td>3.30</td>
</tr>
<tr>
<td>KF6</td>
<td>% reporting good communication between senior management and staff</td>
<td>24%</td>
</tr>
<tr>
<td>KF10</td>
<td>Support from immediate managers</td>
<td>3.62</td>
</tr>
<tr>
<td>KF2</td>
<td>Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.78</td>
</tr>
<tr>
<td>KF3</td>
<td>% agreeing that their role makes a difference to patients / service users</td>
<td>88%</td>
</tr>
<tr>
<td>KF27</td>
<td>% reporting most recent experience of harassment, bullying or abuse</td>
<td>41%</td>
</tr>
<tr>
<td>KF21</td>
<td>% believing the organisation provides equal opportunities for career progression / promotion</td>
<td>83%</td>
</tr>
<tr>
<td>KF28</td>
<td>% witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>32%</td>
</tr>
<tr>
<td>KF17</td>
<td>% feeling unwell due to work related stress in last 12 months</td>
<td>39%</td>
</tr>
<tr>
<td>KF4</td>
<td>Staff motivation at work</td>
<td>3.87</td>
</tr>
<tr>
<td>KF25</td>
<td>% experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>29%</td>
</tr>
<tr>
<td>KF26</td>
<td>% experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>28%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

The trust did not propose to have a specific staff survey action plan, as they told us may themes need to be addressed through the 2021 strategy and the workforce programme within it (the People Strategy, currently being addressed through the 2021 workforce programme).

The trust was to respond to staff openly and honestly about the results and what they were planning to do as a result. The trust wanted to identify ‘quick wins’ to tackle some of the issues
identified. For example, one “quick win” was focused communication around the big issues for staff e.g. how concerns about staffing are raised/why staff are moved at the last minute on wards (but how it can be made a better experience). We saw how many key leaders in the trust had demonstrated the process followed in a video. This described the shop floor to board decisions around staffing levels and moving of staff. It facilitated a greater awareness of the decision-making process for front line staff who may be affected.

At the time of our inspection the trust was reviewing other ideas that had come forward from staff side and the senior leadership forum.

The trust recognised the importance of ownership of the survey results beyond the board. They had undertaken many “big conversations” with staff on each site to review the results, focusing on the issue of staff health and well-being and to gather ideas on the “quick wins” that would demonstrate momentum in tackling the themes emerging.

The results of the Staff Survey have been shared and discussed with the clinical management board (CMB). Each clinical directors (CDs) and executive directors (EDs) had been issued with their directorate level reports and asked to work with their Heads of Nursing and General Managers or Deputies to engage staff in identifying their top three areas they were going to work on. CMB would hold CDs and EDs accountable for their response and for demonstrating improvements achieved with and through staff.

The trusts were looking at introducing a dashboard of performance indicators, through which they could visually demonstrate progress against the issues and themes. This would be displayed across the organisation.

The trust through the Occupational Health services offered a range of Health and Wellbeing initiatives to support our employee’s Wellbeing

**Staff Diversity**

As of March 2017, the trust reported a breakdown of staff as follows:

- 79.4% were women.
- The breakdown of staff by age can be seen in the table below:

<table>
<thead>
<tr>
<th>Age band</th>
<th>% of workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 20</td>
<td>0.55%</td>
</tr>
<tr>
<td>21-25</td>
<td>7.26%</td>
</tr>
<tr>
<td>26-30</td>
<td>11.90%</td>
</tr>
<tr>
<td>31-35</td>
<td>10.27%</td>
</tr>
<tr>
<td>36-40</td>
<td>10.51%</td>
</tr>
<tr>
<td>41-45</td>
<td>12.19%</td>
</tr>
<tr>
<td>46-50</td>
<td>14.47%</td>
</tr>
<tr>
<td>51-55</td>
<td>15.31%</td>
</tr>
<tr>
<td>56-60</td>
<td>10.92%</td>
</tr>
<tr>
<td>61-65</td>
<td>5.05%</td>
</tr>
<tr>
<td>66-70</td>
<td>1.32%</td>
</tr>
<tr>
<td>71+</td>
<td>0.25%</td>
</tr>
</tbody>
</table>
• 78.1% of staff disclosed their sexual orientation as heterosexual and 1.34% as lesbian, gay or bisexual with the remainder unknown or chose not to disclose.

• 2.8% of staff disclosed that they consider themselves to have a disability, 82.9% of staff declared that they don’t consider themselves to have a disability with the remainder either unknown or chose not to disclose.

• The breakdown of staff by religion and beliefs can be seen in the table below:

<table>
<thead>
<tr>
<th>Religious Belief</th>
<th>% of workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christianity</td>
<td>57.76%</td>
</tr>
<tr>
<td>Not Disclosed</td>
<td>17.61%</td>
</tr>
<tr>
<td>Atheism</td>
<td>8.93%</td>
</tr>
<tr>
<td>Other</td>
<td>7.31%</td>
</tr>
<tr>
<td>Islam</td>
<td>2.70%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>2.54%</td>
</tr>
<tr>
<td>Hinduism</td>
<td>2.30%</td>
</tr>
<tr>
<td>Buddhism</td>
<td>0.65%</td>
</tr>
<tr>
<td>Sikhism</td>
<td>0.16%</td>
</tr>
<tr>
<td>Judaism</td>
<td>0.04%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P108a Annual Quality, Diversity and Inclusion Report 2016-17)

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery staff (%)</th>
<th>Nursing and health visiting staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>3.37%</td>
<td>3.14%</td>
<td>24.60%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.23%</td>
<td>0.03%</td>
<td>2.13%</td>
</tr>
<tr>
<td>Asian</td>
<td>4.21%</td>
<td>0.0%</td>
<td>1.06%</td>
</tr>
<tr>
<td>Black</td>
<td>0.67%</td>
<td>0.01%</td>
<td>0.30%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.43%</td>
<td>0.03%</td>
<td>0.04%</td>
</tr>
<tr>
<td>Other</td>
<td>1.23%</td>
<td>0.0%</td>
<td>0.28%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>0.25%</td>
<td>0.0%</td>
<td>0.10%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Staff Diversity tab)

Workforce race equality standard (WRES)

The Workforce Race Equality Standard (WRES) is designed to help organisations gauge their current state of race equality and track what progress is being made to identify and promote talented black and minority ethnic (BME) staff, as well as helping to eliminate wider aspects of discrimination in the treatment of BME staff.

The WRES takes a small number of indicators and requires NHS organisations to close the gap between the BME and white staff experience for those indicators.
The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

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

<table>
<thead>
<tr>
<th>NHS staff survey indicator</th>
<th>Proportion of respondents answering “Yes”</th>
<th>% difference between BME and white staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BME staff</td>
<td>White staff</td>
</tr>
<tr>
<td>KF25: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>Trust</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>All acute trusts</td>
<td>28%</td>
</tr>
<tr>
<td>KF26: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>Trust</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>All acute trusts</td>
<td>27%</td>
</tr>
<tr>
<td>KF21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>Trust</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td>All acute trusts</td>
<td>75%</td>
</tr>
<tr>
<td>Q17b: In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>Trust</td>
<td>16%</td>
</tr>
<tr>
<td></td>
<td>All acute trusts</td>
<td>15%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

The trust has a senior leadership forum comprising the top 200 members of staff. We were told this forum was over represented by BME staff that were predominantly medical staff. The senior leadership forum in March 2018 focused on equality and diversity and inclusion.

There was an equality forum chaired by the chief executive. This reports workforce issues to the workforce/OD Committee and patient issues to the quality governance committee then on to trust Board

The percentage of BME staff employed by the trust had risen in the last 12 months, from 10.9% to 11.34%. This was significantly higher than the resident population in the County. It was noted that 65% of the clinical medical and dental workforce were from BME backgrounds. Outside of the medical & dental workforce there were no BME staff above agenda for change band 8C.

The WRES data shows that white staff are more likely to be appointed from shortlisting than BME staff, with BME staff more likely to enter the formal disciplinary process. Harassment and bullying from patients and relatives had increased for all staff, however it was significantly higher for BME staff. Although high numbers of BME staff reported harassment and bullying from staff and
managers this had decreased since 2016. This showed a change in culture.

There was an increase in the number of staff who report having personally experienced discrimination from work, from 11.7% in 2016 to 14.55% in 2017.

We were told that one of the biggest challenges to be the perception of BME staff re bullying and harassment. There was a zero tolerance to bullying and harassment. The trust ran a zero-tolerance campaign; however, this year’s data had not changed, and the staff survey results clearly demonstrate there is still an issue. The trust was working on a compact with NHS Employers.

The public-sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities. Information on PESED was easily accessible on the trust Internet.

The trust was required to undertake the Equality Delivery System (EDS) Grading Process. The use of the EDS2 helps the Trust to meet and respond to the Public-Sector Equality Duty (PSED) as set out in the Equality Act 2010.

The trust has not completed their engagement events with communities or staff. The Equality & Diversity team reported the trust had started to engage with trans community, developing an active voice within the development of new policies. Additionally, data was available by hospital site and clinical specialty.

The workforce equality monitoring data was published on the Internet, embedded in the equalities annual report.

The ULHT workforce reflects that of the NHS hospital sector, where the majority of lower paid staff are female e.g. nurses. The data for clinical excellence awards demonstrates that there is a difference between the size of the bonus paid to male and female consultants who are eligible, mean bonus pay gap 64.22%.

The equality team were working with the communications team to develop an internal and external strategy. The team reported that one of the key challenges for the organisation is that equality and diversity was not on the agenda/radar for many staff across the trust.

The trust undertook a full staff survey. The CEO reported 43% staff undertook the staff survey, 10% of the respondents were BME, 21% male & 77% female. 20% of the respondents declared a disability.

The trust had developed a number of staff support networks. A BME staff network was established in July 2017. Support for migrant workers was provided through the BME network. The equality and diversity manager reported that BME voices had been actively engaged in developing the WRES action plan, and hold the trust to account through their network meetings. We were unable to verify the effectiveness of this as no BME member of staff came forward to our specific focus group.

A lesbian, gay, bisexual, and transgender (LGBT) network was launched in 2017. The network was developing meaningful engagement across the county using social media.
Each of the staff networks has NED board sponsor. Work was currently underway to engage the executive directors. There was an executive sponsor for the LGBT network; the executive was also undergoing reverse mentoring with a member of staff from the LGBT community. Reverse mentoring is an innovative way to encourage learning and facilitate relationships. It involves the pairing of an employee acting as mentor to share expertise with a senior colleague as mentee

There was evidence of significant amount of work undertaken by the Equality & Diversity lead since he commenced the role in 2016. The key challenge was to articulate the outcomes, embed the actions and effectively engage with staff. It was not clear the degree to which the trust engaged with its BME Network (or similar forum) as a means of sustained and meaningful engagement to influence the trust to mainstream equalities. We saw a number of actions in progress

- Equality strategy was currently in draft and undergoing internal and external consultation.
- Development of a unified equalities action plan for patients and workforce.
- EDS2 grading consultations.
- Engaging executive directors with staff equality networks.
- The Trust was establishing good links with the local NHS economy to focus attention on equality matters.

We were impressed with the development of pastoral support for staff who declare that they did not have a faith, religion or belief.

**Friends and Family test**

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

The trust scored slightly below the England average for recommending the trust as a place to receive care from November 2016 to October 2017.

(Source: NHS England - Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from August 2016 to July 2017 were higher than the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2016 General Medical Council Training Scheme Survey the trust performed worse than expected for three indicators (induction, clinical supervision and feedback) and the same as expected for the remaining 11 indicators.

(Source: General Medical Council National Training Scheme Survey)
We saw a copy of the action plan taken because of the survey results. Actions had been created aligned to each of the concerns.

**Governance**

Prior to January 2018, Clinical governance functions were discharged by a number of teams under three executive leads; quality governance with the medical director, risk management with the deputy chief executive and quality and safety officers with the chief nurse. In May 2017 an external review commissioned by NHS Improvement identified that all teams involved in clinical governance activity should be located within the portfolio of one executive director; consequently, as of 1 January 2018 all teams transferred to the Medical Director.

There was an interim associate director of governance in place support by a head of quality and a head of safety. An advert for a substantive associate director of governance was live at the time of our inspection; this was the second advertisement for this role, as previous applicants had not been suitable.

Following our last inspection, the trust had commissioned an external review of the governance. One of the key recommendations of this review was to develop an integrated governance framework. The trust was using the governance review recommendations as an action plan. We saw the updated version during our inspection. The trust had made some progress with implementing the recommendations; however, for most of the recommendation pace had been slow. The newly appointed interim chair would be pivotal in some of the recommendations in the report and we were told that they were addressing them.

The trust board met regularly and provided an opportunity for scrutiny to members of the public as well as internally. Meetings were held in two parts, the first being in public. The board then met in private to deal with confidential business, typically consisting of personal information and/or information which were sensitive. The board was focused on patient safety and quality as evidenced by the agenda. There appeared to be less focus on finances.

We were told by a number of executives and non-executive directors that board meetings lasted too long and that papers for the board papers for the meeting were often sent out late and were not presented in a consistent way to help interpretation. This meant that the board did not always have chance to prepare for meetings. NEDs told us that often there would be verbal updates at the board with no papers. They also informed us that some decisions had been made prior to board and that therefore there was no opportunity to be involved in strategic decisions in the trust.

At the time of our inspection the governance structure within the trust was under review. The current governance processes were not fit for purpose; this was also reflected in our discussions with the executive and non-executive directors during our inspection. We were told that the quality of governance meeting did not always provide appropriate assurance to the board. The organisational structure was complex. There were a large number of directorates (when compared to other organisations) with a mix of site based and service based clinical directorates. The structure did not support effective and efficient performance management, responsibility, decision making, consistency and accountability. The complexity of the organisational structure did not support good governance and management. Work had started, supported by external consultants, to improve organisational structure. The trust was working to strengthen the governance processes and were out to consultation at the time of our inspection. Some NEDs told us they were not aware of the new governance structure and had not been part of the plans.

We were told the lack of governance processes had a massive impact on the way that the trust responded to external regulators. There was a lack of systems to provide the information
regulators required. This in turn took up additional time from executive directors resulting in a lack of capacity to move forward at pace.

We saw that reporting mechanisms such as to external bodies was not aligned into trust current governance. For example, the trust had been reporting to the CQC on a weekly basis in relation to the emergency department at Pilgrim Hospital, but these had not been through the subcommittees and the board. We were told there was a risk the trust was being reactive and focusing on trying to get out of special measures, rather than making process business as usual.

Executive directors told us that previously there had been a lack of governance processes around financial spending, and that standing financial instructions (SFI) were not robust. SFIs detail the financial responsibilities, policies and procedures to be adopted by the trust; they are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy to achieve probity, accuracy, economy, efficiency and effectiveness. Our findings during inspection show that not all governance assurance was in place or embedded. We were told by executive directors that there was plans to highlight concerns at the next audit committee.

The integrated performance report was under review at the time of our inspection as the data was of poor quality and did not always provide assurance, furthermore there was minimal evidence of triangulation and the data was in silos. An executive director was working to improve the integrated performance report. We found that the board were not always assured of the safety and quality through its governance structures. We found that information and data type used by the board to gain assurance did not always provide the full picture for example we noted the data narrative in relation to pressure damage within the integrated performance report for February 2018, the report was not aligned to the graphs and therefore assurance could not be provided. We noted in the board minutes from January 2018 there had been an error in the graph and the number of medication incidents. The newly created performance report would address this.

We heard from a number of executive directors and NEDs that data often included in the board report was not accurate, this meant there was not sufficient assurance to the board. There were gaps in the assurance process, there was no evidence of learning because of complaints or incidents were followed up. We were told that the trust were data rich but did not use the information intelligently. We noted the minutes from the board meeting held in March 2018. The quality governance committee stated limited assurances had been received. Limited assurance had been given in respect of falls, pressure ulcers and infection control. The minutes went on to say that the committee received lots of information in respect of patient experience however this could not be triangulated so could not be used assurance.

We found a lack of governance processes around the procedures to ensure locum staff were suitable to work in the organisation. Although a standard operating procedure was in place for the directorates which included a checklist, this was not audited; therefore, there was no assurance that this process was being completed.

The Royal College of Surgeons Standards for Children’s Surgery (2013) sets out a range of guiding principles to help support organisations to deliver surgical activity within a safe and appropriate environment. It was recommended that a defined governance structure existed to assure the board of the quality and delivery of surgical care to children and that this should be overseen by a multi-disciplinary children’s surgery committee which reported to the board. At the time of the inspection such a committee or governance structure did not formally exist.

During the inspection of children’s services, we were informed of a serious incident that had occurred in 2017. A patient, who was also a patient of a local mental health service, had been
admitted to the ward and required one-to-one supervision. Senior nursing staff informed us the patient was receiving one-to-one care from health professionals who worked at the mental health service. We queried whether the trust had undertaken any checks of those health professionals to ensure the trust was meeting the requirements of Regulation 18, Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Regulation 18 requires registered health providers to carry out appropriate checks on perspective and current staff to ensure they are suitably fit and proper to carry out their role. This includes checks to determine whether individuals have been placed on a barred list, and so are prevented from working with children or vulnerable adults; character references, identification and employment history. The trust responded by stating, “The [patient] was admitted from [another service] which is a residential mental health setting and as such employment checks are the responsibility of [that provider] as identified in their Safeguarding and Child Protection policy”. This is contrary to the requirements of Regulation 18 which makes no provision for permitting registered providers from discharging their legal requirements to comply with the regulations by permitting other registered providers from undertaking checks on their behalf. The trust acknowledged they would review their systems and processes in relation to the governance of potential carers providing direct supervisory and/or clinical care within the acute hospital.

We reviewed a number of committee meeting minutes and found that discussions we were told about were not reflected in the minutes. We were told there was a lack of administrative functions for the committees and the minutes were often slow to be developed. We saw how there were gaps in bringing together all the different committees. For example, the clinical effectiveness steering group linked with the quality governance committee but there was a gap between them and NICE guidelines. There was a system in place to implement NICE guidance compliance; however, one executive director told us they were not aware of what the gaps in assurance are with these and could not be assured they were monitored. We saw how quality reports went through various subcommittees of the board but there was no summary to the quality governance committee.

There was a newly appointed interim NED who chaired the quality committee at the trust. The terms of reference for this meeting had been reviewed; however, we saw there were key elements that were not in place. The NED had only been in post since March 2018 was working to strengthen this committee. There was a need to strengthen the reporting from directorates to directorates through to sub committees.

The terms of reference for the audit committee were in the process of being reviewed at the time of our inspection and developing the terms of reference for this meeting. The plan was to ensure that the committee was functioning effectively within the next 12 months.

The senior directorate team described the clinical governance system as starting at ward level. This meant governance issues and assurance were connected directly to directorate-level governance structures, which were overseen by heads of service. Clinical cabinets for nursing and governance maintained oversight of governance outcomes and the triumvirate leadership teams reported into patient safety committees. Each cabinet team attended a monthly operations meeting and clinicians and matrons attended monthly meetings for job planning. Each medical specialty held their own governance meetings and the clinical director joined them as needed to provide oversight of the assurance process. These meetings were supported by quality safety officers. We heard from a number of executives that they were concerned about the capabilities of the groups below the subcommittees of the board, particularly in relation to how reports were written, assurances obtained and data interpreted.
We were not assured that senior divisional teams were always responsive to the risks identified by ward-based teams. For example, a multidisciplinary team on a medical ward worked together to identify the level of poor practice in the hospital in relation to maintaining good fluid balance in patients. They identified this as a significant risk and identified to the trust board that this could be improved if fluid balance was introduced as a mandatory training topic. The trust refused this and did not engage with the project team over other options. Instead staff used local time and budgets to deliver training. Although this meant safety standards were improved in certain areas it meant there was not a consistent approach across the hospital.

We saw there was variability in term of the effectiveness of speciality and directorate governance meetings. The trust had relaunched the speciality governance toolkit to support local clinical governance meetings. We noted from the March 2018 board meeting minutes that the deputy chief executive questioned how much assurance was provided from the speciality governance arrangements. Executive directors confirmed there was a lot of work still to be done to develop and embed these processes.

We found a number of policies and procedures on the trust intranet that were past their review date. Executive directors were aware of the problem and that whilst the policies remained online they were being reviewed. A new post had been created in the HR team purely focusing on policies and procedures. We were also told that policy reviews with staff side had been reinstated.

Senior leaders in pharmacy expressed concerns that they were not able to escalate safety concerns appropriately as they were not linked at a sufficiently senior level in the trusts governance structures. However, in the pharmacy business plan, we saw that there was intended to be direct access to the board for their statutory roles and access through the Medical Director for quality governance issues concerning Medicines Optimisation.

We saw an assurance report from the Medicines Optimisation and Safety committee that was sent to the patient safety and quality committee. This provided assurance that relevant safety alerts had been actioned and identified pharmacy services and medicines optimisation risks within the organisation.

Clinical cabinet meeting had been introduced since our last inspection. These were attended by the director of nursing and each ward manager and matron. Ward performance metric data was discussed at this meeting. This had influenced appropriate ownership of ward performance and was away of increasing accountability. Improved and sustained performance was also discussed at this meeting.

A newly developed nursing assurance framework which was supplemented by a daily assurance ward visit “golden hour” and ward accreditation had been introduced since our last inspection. The framework outlined the process of ward managers to matrons to head of nursing assurance meetings upwardly reporting to nursing cabinets which were chaired by the director of nursing.

The trust had recently introduced a ward accreditation process which would provide reports to all levels of the governance process.

There was a programme of audit, which included national and local audits, and these were used to identify areas for improvement. Audits included both clinical and non-clinical areas although we were unable and told by executive and NEDS there wasn’t awareness on how audit schedules were populated or agreed / signed off. Despite actions plans being created following audits, there was not an established process in place for ensuring that appropriate learning took place and improvements had been made.
Board assurance Framework

The trust provided their Board Assurance Framework as of October 2017, which details six strategic objectives with accompanying risks. A summary of the strategic objectives is below:

- Consistently high quality and safe patient care
- A clinically responsive organisation
- Services shaped around patients’ needs
- Objective: Skilled, competent and motivated workforce
- Performance Improvement
- Financial stability and recovery

(Source: Trust Board Assurance Framework)

The board assurance framework lacked a number of actions needed to address gaps in control. The trust recognised that the BAF did not always correlate to the risk register and needed to be refreshed. We saw a copy of a newly drafted BAF that was to go to board in April 2018; there were significant improvements in the draft. It would be rewritten in line within a new process for management of risk registers, so that both aligned to each other.

The improvement programmes across the trust as highlighted in the vision and strategy section of this report was monitored and managed as part of the 2021 programme. There were clear governance structures and reporting to delivery boards led by each of the directors as senior responsible officers (SRO) under the overarching responsibility of the deputy chief executive. The SROs provided updates to the 2021 programme board on the progress of delivery for assurance to the trust board.

Processes were in place for a local NHS trust to handle administration systems relating to Mental Health Act administration functions. The local mental health trust also provided psychiatric liaison services through a local agreement. This trust was aligning policies with the Psychiatric Liaison Accreditation Network in a bid to become a member. However, the two organisations did not hold combined governance or risk management arrangements. Staff had been trained in relation to caring for patients detained under the Mental Health Act. A ‘grab and go’ resource folder in each site operations centre included all paperwork and guidance. Following detention, staff maintained a central log of detained patients in the operations centre.

Staff had access to a multi-agency case review system, which enabled a reflective learning process undertaken following a detention and to ensure staff followed policy; these were then presented to the Mental Health and Learning Disability Strategy Group. The group developed a Mental Health intranet page where all relevant information and documents were available.

Management of risk, issues and performance

Whilst the trust had systems in place to identify learning from incidents, complaints and safeguarding alerts to make improvements, these were not functioning effectively. There was no triangulation of identified themes and no robust process for following up on learning to ensure this had been embedded.

Fully effective arrangements for identifying, recording, and managing risks, issues, and taking mitigating actions were not yet in place. At the time of our inspection risk management was under review as part of the risk governance improvement plan. This improvement intended to refreshed
policies and procedures with clarity of roles and responsibilities and included incident management. The arrangements for the identifying, recording and managing risks were not robust. Executive directors told us there needed to be a fundamental change to how risks in the organisation informed decision making.

The trust had appointed a risk manager since our last inspection. The risk manager had been in post three months at the time of our inspection. The risk team included one risk officer and three risk supporting officers.

There was a lack of clear links between the board assurance framework and the corporate risk register. There was limited consistency in the rating of risk and executive directors were not assured that not all risks were identified. There was a lack of clear links between the further control and mitigating action and the wording of the risk description.

We saw a report which had gone to trust board in April 2018. The report proposed a new BAF with revised strategic risk definitions. It proposed a direct link between strategic and risks and the corporate risk register, which in turn would link to the operational risks that would make up the directorate risk registers. A new template for the board assurance framework was in draft with the intention to link this directly to the risk register.

At the time of our inspection anyone could put a risk on the register, however it was envisaged that directorates would manage their own risk registers and that the operations risks would form the directorate risk register.

The trust provided a document detailing the 128 highest profile risks. Each of these had a current risk score of 15 or higher. The 32 highest profile risks had a risk score of 20 to 25. We were told that the risks on the current register although reflected the current risks, there was no assurance the board were sighted on other risks which may exist within the trust. We were told that the number of risks on the register could be reduced, if directorates managed their own risk. The risk manager told us that he was not assured that the current risk scores on the register were accurate and the risk scores may be lower for some. Executive directors did not have ownership of risks within the trust.

There was a separate pharmacy risk register and items were escalated when they hit a specific level of risk. The most recent item to be referred to the trust risk register was the aseptic units within the trust as they were becoming unfit for purpose. The pharmacy and medicines optimisation business plan (strategy) included action plans to address risks on the pharmacy risk register. In our discussion with executive directors in relation to pharmacy, they were not clear on why this issue had been escalated. This is a significant patient safety concern and this highlighted concerns with the understanding of patient safety risks in relation to pharmacy executive director level. We were not assured there was sufficient board oversight of pharmacy.

We saw data to show that benchmarking was identified using the pharmacy and medicine section of the model hospital report. We were told this was viewed regularly. Areas for development were included in the pharmacy and medicines optimisation business plan (strategy).

There was an ineffective quality impact assessment (QIA) process. Some decisions were often made without a QIA being formally documented. Following concerns raised in relation to the number of staff competent to care for children in the Emergency Department at Pilgrim Hospital, a decision was made to reallocate three nurses to the ED. This was not fully risk assessed and no form quality impact assessment had been undertaken. The decision to move nurses to ED resulted in the children’s nursing team determining that, to meet Royal College of Nursing recommended safe staffing standards, there would need to be a reduction of inpatient beds from 19 to eight beds. This decision generated further risks within the emergency care pathway for
children at Pilgrim Hospital. There was no capacity and demand modelling undertaken to offer assurance to the board that eight beds would be sufficient to meet the needs of the population. Furthermore, medical staff reported the challenges of having to either transfer patients or clinically prioritise patients for admission, thus increasing the need for patients to return as “ward attenders” as a means of trying to manage risk.

We heard because of the cost improvement programme a number of cost improvement programmes (CIPS) had been proposed, however the board were not always sighted on these. The director of nursing and medical director was involved in assessing all CIPS which may affect patient care before signing these off, we heard how external support had been sought, when auditors had proposed a change to the agency spend / nursing establishment. The trust involved the local clinical commissioning group with any financial CIP / QIA processes. We also heard how other clinicians would be involved in the “challenge and confirm” process for CIPS. The trust planned to have a QIA / CIP panel from May 2018; this would also include a NED. This would strengthen the QIA / CIP process. There was no formal monitoring of changes because of CIP / QIA for potential impact on quality and sustainability.

The Getting It Right First Time (GIRFT) programme aims to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving patient outcomes. The trust had a number of GIRFT reviews across a number of specialities. We saw how actions because of GIRFT in orthopaedics had improved service efficiency.

Each ward had a safety and quality dashboard that was used to monitor risk, performance and quality. This included an overview of contributing factors such as incidents and accidents as well as data from the NHS Safety Thermometer. The dashboard provided an overall score and enabled ward teams to quickly identify where they needed to focus improvements and where they were achieving a high standard.

We saw there was a process in place for pulling together internal risk summits. Risk Summits provide a mechanism for key stakeholders to come together to share and review information when a serious concern about the quality of care has been raised. We saw how risk summits had been carried out in relation to concerns around paediatric staffing at Pilgrim hospital. Staffing levels and the retention and recruitment of skilled and qualified staff in paediatrics had existed for some two years prior to the inspection. The trust had held a number of internal risk summits to consider the impact and implications however there had been little in the way of effective management of the situation. A presentation to the private section of the board in September 2017 set out the staffing concerns. The board agreed they would support the escalation of concerns to community stakeholders on 6 September 2017 and that the matter had been listed as resolved within the private board papers of 5 September 2017. Discussions with the lead commissioner confirmed that consideration was being given to the future of children’s services as part of the sustainability and transformation plan however there was currently no definitively agreed strategy. The trust had not considered nor implemented contingency plans in a cohesive and timely way.

The director of finance and the chief executive met monthly with the directorates to discuss performance including financial performance.

Prior to our inspection we were aware of a significant backlog in the number of historical serious incident investigations. There had been some improvements in the numbers of serious incidents being reviewed and we saw a trajectory which suggested the backlog would be complete by June 2018. The longest serious investigation awaiting review was from November 2017. At the time of
our inspection a new model for investigating serious incidents was being trialled. A core group of staff were investigating and writing reports for serious incidents. A flow chart had been created to support this process. Roll out of training known as “Hearts and Minds” would be rolled out to senior clinicians in the directorates to support this process.

We reviewed a sample of completed serious incidents reports. The quality and content of the reports was variable, some reports had key information such as the patients date of birth missing, did not evidence how the patient and family were engaged in the investigation process. There was no evidence of how the trust supported staff that provided care to the patients, or involve any other agencies involved in the care of the patient. However, all the reports had established facts about the incidents and had identified and documented learning actions including the plan for sharing.

Where care management and service delivery had contributed to the serious incident we saw how the action plan addressed rectifying these in detail.

A weekly meeting was held chaired by the director of nursing and or the medical director. This brought together clinical staff to discuss serious incidents. Clinicians would present the 72-hour investigation report and a decision would be made as to if this met the serious incident criteria and decide if further investigation was required, at this point the incident would also be logged on the StEis system. We attended one of these meetings during our inspection. We were not assured that the panel had considered immediate actions to learn from the initial incident, nor did we see that duty of candour was discussed. Clinical staff told us during the inspection that they found this meeting useful and supportive.

We carried out a review of low or no harm incidents reported between 1 March and 31 March 2018. A total of 1250 were reported of which at the time of inspection (April 2018) 529 had been closed. We were told that an improvement had been made to the process within the trust since our last inspection. Prior to this all low or no harm incidents were closed in batches after being open for 30 days or more. This was now managed at local level so that learning from low or no harm incidents could occur.

The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes from regulations of the Coroners (Inquests) Regulations 2013. The report is sent to the people or organisation who can act to reduce the risk. They then must reply within 56 days to day what actions they plan to take. We saw a number of regulation 28 reports where actions plans had been created, however the actions had not been implemented or embedded in practice. We were told that there was no follow through in the trust of these reports and therefore there was a lack of assurance at board level. We did not see regulation 28 reports form part of the integrated performance report.

The trust included tracking of referral to treatment times (RTT), cancer wait times, and the emergency care standard and diagnostic performance in the integrated performance report. These were reported through the trusts governance structure. The achievement of national targets was a challenge for the trust. The trust had plans in place to improve the emergency care standard, cancer waiting times and access targets. The trust was working with stakeholders where system pressures affected the trust’s performance. Work had been undertaken in the emergency departments to try and improve performance; however, this had not brought about significant improvement. The trust was receiving additional support from an external agency to look at systems and processes in the department.
There had been failures in processes intended to keep patients protected from avoidable harm. There was a need to embed learning from never events to prioritise safety and reduce the numbers of never events. Three never events, which had resulted in no harm were reported since our last inspection in October 2016. One of the never events had been repeated from the previous year. Whilst there was no particularly theme to the never events, some of these were previous patient safety alerts issued through the national central alerting system. The trust had investigated the root causes of the never events and found that staff were not always following policies and procedures. We found no evidence of monitoring of actions taken from route cause analysis.

Following an unannounced inspection in February 2018 to the emergency department at Pilgrim Hospital. We took urgent action under the Section 31 of the Health and Social Care Act, as we believed a person would or may be exposed to the risk of harm if we had not done so. We imposed a number of conditions on the trust registration which meant that they had to report to us on a weekly basis on the actions taken to address our concerns. Executive directors had been sighted on some but not all the concerns we identified. Actions previously taken had not been sufficient to address the risk and the pace of change had been slow.

The Trust had significant issues with estates compliance with fire safety regulations which resulted in the fire service taking enforcement action in 2017/18. The Trust was implementing a fire safety improvement plan over a three-year period (2017/18 – 2019/20) to fully address fire safety risks.

**Finances Overview**

The Trust’s financial and operational performance in 2017/18 does not evidence effective processes for managing risks, issues and performance. The Trust did not deliver its 2016/17 financial plan (plan £47.9m deficit, actual £66.5m deficit), and has significantly under delivered its financial plan for 2017/18. The Trust had reported significant variance from its 2017/18 financial plan since the start of the financial year. The actual financial position had been worse than plan due to inadequate planning, slow start to CIP delivery, operational pressures and some non-recurrent in-year events (e.g. fire, cyber-attack, snow, elective cancellations). The Trust was expected to deliver a full year deficit of £83-84m, £20-21m deterioration on its planned position, and reforecast outturn position of £77m (Trust reforecast at Q3 2017/18).

In 2017/18 NHS Improvement placed the Trust in special measures for finances due to a significant deterioration in the Trust’s financial position in 2017/18 and its large deficit. The Trust was set a 2017/18 control total deficit of £63.3m (excluding sustainability and transformation funding of £14.7m). In December 2017 the Trust Board reforecast the expected forecast outturn position as a best-case year end deficit of £77m. The revised forecast outturn deficit is the mitigated position which includes action being taken to improve financial control and deliver an efficiency programme of £16m. Failure to deliver the Trust’s control total had resulted in lost sustainability and transformation funding (£14.7m) and additional cash support for revenue costs.

The Trust has an ambition to deliver £30m of efficiencies in 2018/19 and was working to identify and implement additional schemes to increase the already identified £19.7m.

Tracking delivery of overall financial recovery plan by the trust was described as:

- Progress against the Finance recovery plan to be presented to Executive Team twice a month
- Finance is one of five key priorities for each Board meeting (the others being quality, fire compliance, A&E performance and Cancer performance)
- Performance meetings with Clinical Directorates will include a focus on finances to raise concerns around slippage and ensuring delivery is on track
• 2021 Finance strategy group already developed and approved an efficiency framework and to lead on developing a long term financial model
• All efficiency ideas to be documented and to go through a Quality Impact Assessment (QIA) sign off process before being adopted.
• Executive or Clinical lead sponsor for each efficiency scheme
• Capacity and capability to deliver to be addressed, in part by recruiting to 2021 programme management office.

The board oversaw financial performance at monthly board meetings and through the monthly FSID committee meeting.

Delivery of the financial efficiency programme ('FEP') was tracked through executive meetings and at the board. NHS Improvement also oversaw financial improvement through regulatory meetings about financial special measures (FSM).

Prior to the current substantive executive team being fully in place and prior to the support it has received under FSM, the Trust had never historically delivered cost improvement plans (CIP) in a meaningful way. The infrastructure now in place to support CIP development and delivery was a significant improvement on what was in place previously, but was still relatively new and could be strengthened. The Trust was reliant on external support to drive CIP development and CIP monitoring (excepting quality impact assessment of CIPs which remains the trust’s own responsibility). It had an outline transition plan to address its current reliance on external support and replace this with internal resource.

The trust was reliant on external support to operationalise development and implementation of some strategies to mitigate risks. Whilst, for example, the trust would lead discussions with commissioners to affect resolution on any items of dispute that present a risk to the Trust’s position, it is reliant on external support to help identify and develop mitigating CIPs, where these are being used to mitigate other arising financial risks.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident. There were robust plans in place for seasonal pressures which included a capacity flow and escalation policy. The policy outlined the day to day operations of all sites and roles and responsibilities of key members of the team. We saw the business continuity plans worked effectively during our core service inspections because of adverse weather conditions and increase pressure on the healthcare system.

**Information management**

The board did not always receive holistic information on service quality and sustainability. The integrated performance report did not always provide the full picture to assurance. Board members consistently told us they did not have the confidence in the quality of the data presented. There was no formal process for monitoring quality of data.

In 2017/18, the trust commissioned a review of activity coding and counting data which found that there was significant under coding and counting of activity resulting in an income shortfall for the trust.
The Trust was identifying efficiency opportunities highlighted by the model hospital. CIP plans for 2017/18 were expected to build on the analysis of model hospital data to deliver financial efficiency savings.

There was a weekly patient tracking list (PTL) meeting to proactively manage patients who were experiencing long waits, patients on cancer pathways and the referral to treatment times.

The trust had a real-time dashboard, which captured emergency department data. Data was subsequently used to create a sitrep report.

The trust had a contract with Dr Foster and used the data from Dr Foster to proactively test and challenges its own performance. The trust was using national indicators to benchmark themselves against other organisations.

The data management team had worked with local teams to improve payment for the best practice tariff for fractured neck of femur.

Since our last inspections the trust had implemented an electronic observations and sepsis management system, this meant that staff had a view of all patients early warning scores at the point they were undertaken. The number of missed or overdue observations had improved because of this system and the number of patients who were screened and treated for sepsis had improved.

Patient management software systems had been upgraded since our last inspection. Leaders described this as a much more robust programme as it prevented staff from bypassing certain parts of the system and hence required all data input to be completed. The trust had moved to an electronic discharge document and staff described that there was an improving picture in the number of patients who had an electronic discharge summary completed.

Arrangements to ensure the confidentiality of identifiable data were not always robust. During our core service inspections, we saw on a number of occasions patient identifiable information left unattended for example medical notes left open and unattended and notes trolleys unlocked.

The trust was part of a radiology consortium. The consortium worked with a healthcare technology supplier to create radiology IT system capable of handling millions of patient events. The system allowed clinicians to access the complete radiology imaging record for all patients across a number of trusts in the consortium this included scans, reports and clinical opinions.

NHS England introduced the Accessible Information Standard (AIS) in all organisations that provide NHS or Adult Social Care. The trust recognised that there was still work to do in terms of their systems being able to automatically generate information in the patients required format and to become fully compliant with the AIS. An action plan had been agreed with the CCG. For example, we were shown an example of meeting the communication needs of patients in a consistent manner. The trust had agreed to support the inclusion of the AIS in the Hybrid Mail – an automated system that supports accessible information functionality.

The trust engaged an external company (360) to conduct internal audits to provider assurance around data quality and the trust had a data quality assurance group which met fortnightly.

The various board sub-committees challenged trust key performance indicators (KPIs) and data quality. Members of the executive team and non-executives also challenged data quality and data recording/capture through regular patient safety walkabouts around wards and clinical areas.

Regular work was undertaken by the data quality team to review key reports on items that affect downstream reporting, as well as part of monthly reviews from commissioners on contract challenges, known as Acute Invoice Validation (AIV) queries.
The systems of monitoring, management and reporting the milestones of the strategy and the improvement programmes were manual utilising Excel and Word, however, the trust was migrating to an integrated enterprise management solution to provide streamlined performance management and reporting of all the measures, programmes and projects in the 2021 strategy.

We did not see evidence of KPIs in operation in the pharmacy department, although pharmacy submitted a quarterly assurance report to the Quality Governance Assurance Committee relating to the pharmacy service. Areas of performance such as medicines reconciliation rates and clinical pharmacy activity were measured as part of the model hospital benchmarks.

The NHSI deep dive into pharmacy services in the trust along with the previous CQC inspection identified lack of pharmacy involvement with discharge medicines resulting in errors. We heard from the staff that there was a project underway to quantify this risk to provide evidence to support a business case to fund additional staff to better support discharge.

Incidents, including serious incidents, were mostly reported as required to the NHS National Reporting and Learning System (NRLS) or the NHS Strategic Executive Information System (StEis) in a timely way. There had been significant improvement since our last inspection in the timeliness of the submissions to NRLS and StEis.

The trust submitted notifications to the Care Quality Commission in the past year in line with their statutory responsibilities. The commission received notifications about never events that occurred and safeguarding. In addition to the statutory notifications, the trust provided additional information when requested such as 72 hour and serious incident reports in an open and transparent way. Following our inspection of urgent and emergency care we required the trust to report to us on weekly basis actions taken to address the concerns we had raised. The trust has continued to submit these in a timely manner as requested in line with the conditions on their registration with the Care Quality Commission. External stakeholders reported no concerns with regards to the trust facilitating them with required information.

At the time of our inspection (April 2018) the trust had self- assessed itself against the information governance toolkit. All components of the information governance toolkit in relation to data quality were self-assessed as the levels two or three with information governance scoring level one. Information governance training was at 84% and the trust were working to improve this.

IT systems and telephones were working well and they helped to improve the quality of care. Staff generally had access to the IT equipment and systems needed to do their work.

The board were aware of national risks, including cyber-security, and supported information management and technology colleagues to ensure appropriate strategies and systems were in place. The trust was as safe as they could be in relation to cyber-security. They kept up-to-date with threats and ensured their systems were updated regularly to protect them from these threats.

Engagement

The trust had a structured approach to engaging with people who used their services, those close to them and their representatives.

The trust had a core group of patient representatives. Patient representatives sat on a number of trust wide groups such as complaints, estates and outpatient improvement group. Patient representatives told us the trust were receptive and are welcoming of challenge from the group in relation to patient experience. Patient representatives were encouraged to report concerns and could follow up on actions taken because of their concerns.
Ward staff and divisional teams had access to feedback from patients, carers; however, it was not always used to make improvements in services.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. The communications team maintained a high social media profile and were increasingly using this as an additional means of engaging with the local population. We also saw local ward newsletters and the trust magazine ‘LincolnshireWire’ magazine for staff, patients, GPs, volunteers and all local people.

Patients, carers and staff had opportunities to give feedback on services they received, however there was a low percentage response rate to the friends and family test. A report on patient experiences findings because of engagement activity was taken to the trust’s Patient Experience Committee bi-monthly, so that action could be taken within services on the findings reported. An example of where engagement had influenced change is a visit to the Lincoln Macular Society, where concerns were raised about the care of patients with macular degeneration. These were fed back to the service lead, who worked with consultants in the service to improve communication with patients, to speed up the process of appointing eye clinic liaison officers for Lincolnshire and review the process for registering patients as blind.

The trust has developed a local "pulse" survey to supplement the data gathered from the national staff survey. There were a number of standard questions in each survey; with some additional questions added each time the survey was run to look at specific topics. There had been a staff survey within the pharmacy team and this has resulted in the introduction of workshops to capture the ideas and views of the staff.

The trust sought to actively engage with people and staff in a range of equality groups. We saw several groups such as BAME and LGBT were set up by the trust. The trust had engaged with the deaf community the themes had been reported in the patient experience committee and to the management of the Trust’s hearing aid clinics. As a result, the trust had introduced a new patient wristband to more easily identify patients with sensory impairment; however, we did not see these in use during our core service inspections.

Staff were not always involved in decision making about trust services. We heard from many clinicians how they weren’t sure what was going to happen to their service and the acute service review process was unsettling.

Patients, staff and carers we able to meet with the members of the trust leadership team to give feedback. Staff described the executive directors as approachable. The board started each meeting with a patient story which is presented by either the patient themselves or a member of staff.

Trust leaders engaged, on behalf of front line staff, engaged with external stakeholders such as healthwatch.

The trust was actively involved and engaged in collaborative work with external partners and actively engaged with the local STP. The chief pharmacist was chair of the local STP pharmacy and prescribing group. This addressed factors impacting on patient care in both primary and secondary care. We saw that recent items under discussion included: the discharge process from ULHT and, the area prescribing committee that had representation across healthcare interfaces in the area.

External stakeholders said they received open and transparent feedback on performance from the trust. Stakeholders described a strong working relationship with the trust.
Learning, continuous improvement and innovation

Some staff told us there was a culture of learning and improvement and that training and development was encouraged; however other staff told us there was no time for training or development due to clinical pressures. Staff told us they often didn’t have time to organise and or attend staff meetings, which would be an opportunity to learn and improve. Leaders recognised due to clinical pressures staff meetings were not always possible.

The medical director provided executive leadership for quality improvement. Quality improvement (QI) was shared between the medical director and the director of nursing. The trust had incorporated a quality improvement methodology in the 2021 vision and strategy that. This showed the trust were focusing on quality improvement and that everyone would be involved in this.

The trust was supporting 150 staff to complete Plan-Do-Study-Act (PDSA) training. The PDSA cycle is part of the Institute for Healthcare Improvement Model for Improvement and is a tool for accelerating quality improvement.

The Trust was developing its improvement methodology based on PDSA supported by Health Education England. There is also a history of improvement using the Listening into Action (LIA) methodology which was being used as the basis for improvements at ward/department level.

As part of the trust’s vision and strategy and improvement programme a wide-ranging ward accreditation scheme had been implemented. A team of quality matrons used a quality assessment for each ward that considered staff knowledge and performance in 13 key areas such as safeguarding, identifying deteriorating patients and end of life care. Wards were awarded a status based on the red, amber, green system and were required to submit action plan targeting specific improvements. The first wave of accreditation had been completed.

All the staff we spoke with were positive about the accreditation programme and said it had helped them to identify where they needed to improve and to get help in achieving this. This was a substantive programme of work that demonstrated considerable focus on improving patient safety and outcomes.

As part of the trust’s improvement plan, the matron team had introduced a daily ‘golden hour’. This was protected time ring-fenced for each matron to carry out leadership duties. This was an improvement as historically matrons lost dedicated leadership time due to bed management duties and the requirement to attend meetings, however matrons still felt they had little time for quality improvement because of being drawn into operational pressures, particularly over the winter period.

Further work was required on quality improvement within the organisation which includes closing the loop on processes such as learning from incidents. We heard from many people that action plans are often seen as the end of this process, as opposed to being the start of the improvement. There was not a robust process for testing out quality improvement, to ensure actions had received the intended results or had been embedded.

A refreshed integrated data report was to be taken to trust board in May 2018. This included a financial early warning tool on a ward basis; this would include staffing, sickness and performance metric for example and would be used as an indicator for quality and performance delivery.

The pharmacy team had recently evaluated the placement of a pharmacy technician into a nursing team on the emergency admission unit. This position was implemented to ease nursing pressures,
and reduce missed doses and drug errors. The placement had been evaluated as a success and 
a paper drafted by the deputy chief pharmacist indicated a reduction in omitted doses and a 
freeing-up of nursing staff for other care-related duties. This initially started as a pilot position but 
was now a permanent position on this ward.

We heard that the pharmacy team were meeting with members of the exec team to discuss the 
two NHSI deep dive reports into pharmacy services in ULHT in the near future. We did not see 
any action plans based on these reports although some of the aspects identified in the reports 
were included in the Pharmacy and Medicines Optimisation Business Plan (strategy).

The Learning from Deaths guidance required NHS trusts to produce and publish an updated policy 
on learning from deaths. This should be presented to the board by the end of September 2017. A 
quarterly mortality report should then go to trust the board. The trust had implemented learning 
from deaths policy and the first quarterly mortality report had been presented at a board meeting. 
The trust had also created a mortality reduction strategy 2018-2021, this described how the trust 
would drive and enable change.

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>35</td>
<td>80%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>50</td>
<td>80%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process from September 2016 to October 2017?</td>
<td></td>
<td>4257</td>
</tr>
</tbody>
</table>

*Source: Routine Provider Information Request (RPIR) - Complaints Process Overview tab*

**Number of complaints made to the trust**
The trust received 695 complaints from October 2016 to September 2017. A breakdown of 
complaints by core service can be seen below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>% of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>188</td>
<td>27.1%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>178</td>
<td>25.6%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>152</td>
<td>21.9%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>79</td>
<td>11.4%</td>
</tr>
<tr>
<td>Maternity</td>
<td>23</td>
<td>3.3%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>23</td>
<td>3.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>20</td>
<td>2.9%</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>2.7%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>13</td>
<td>1.9%</td>
</tr>
</tbody>
</table>
The highest number of complaints was reported in surgery (27.1%) followed by medicine (25.6%).

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

The number of complaints has reduced since our last inspection and we saw a marked improvement in the quality of responses. There had also seen a reduction in the number of complainants who were unhappy with their first response. We were particularly impressed with “See it my way”, an approach to responding to complaints from the patient’s perspective.

For the period 2017/2018 the total number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) was zero. The PHSO make final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations.

The complaints team told us that they had sufficient support from executives and all complaints were signed off by an executive before they were sent out to the complainant. The chief executive saw all complaint responses. The complaints team now attended the speciality governance meetings. We were told clinical directors were much more proactive in the complaints process and were taking much more ownership for their directorate complaints.

The trust recognised that seeking, collecting and valuing patient and staff experience would only be evidenced in how the feedback was used. The trust had sought and been successful in securing funding to appoint a data analyst to explore and develop systems and processes for achieving best practice. At the time of our inspection the job was out to advert.

Accreditations

NHS trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made if to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Lincoln County Hospital, Pilgrim Hospital, Grantham Hospital, Louth - Accreditation for 2016. Annual report card submitted in October 2017</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services*</td>
<td>Nuclear Medicine at LCH I - ISO 9000-2008</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Macmillan Cancer Information &amp; Support Centre Boston and Grantham Hospitals achieved 09/11/2017</td>
</tr>
</tbody>
</table>

* The trust has stated that they have an accreditation with the CHKS for the nuclear medicine standard ISO 9000-2008, however the CHKS website does not list the organisation as having this accreditation (the CHKS list was last updated on 13 February 2018).

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

There had been innovation at the trust in many areas. This included:
• ULHT were to lead development of a degree apprenticeship standard for physiotherapist and occupational therapist. ULHT had been given government approval to lead on the development of the first ever degree apprenticeship for the roles of physiotherapist and occupational therapist (OT). The degree apprenticeship hoped to boost numbers of physiotherapists and occupational therapist roles in a bid to tackle both local and national staffing shortages. It will provide an alternative route for those wishing to become a registered healthcare professional but who want to combine their studies with on the job training. In the first year, it’s predicted there will be 100 apprentices of which 42 are for Lincolnshire.

• The trust had national recognition for project which recognises the role of carers in hospital. Four innovative pieces of work in ULHT hospitals had been recognised in the national Fab Awards, run by the Academy of Fabulous NHS Stuff. One project, the carers’ badge, came out on top and won the Rosa Parks award, which recognises best practice and innovation across the NHS. The patient experience team created the badge after it was recognised that our staff sometimes struggle to identify who is a carer, and therefore to ensure they can play a role in the care of patients. The badge and lanyards enable carers to be at the hospital 24/7 if they wish, to be present at ward rounds and whenever they need to be.
Urgent and emergency care

Facts and data about this service

The United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. The trust serves a population of approximately 700,000 people, situated in the county of Lincolnshire.

Details of emergency departments and other Urgent and Emergency Care services

Urgent and emergency services were provided by United Lincolnshire Hospitals NHS Trust across three sites:

- Lincoln County Hospital
- Pilgrim Hospital
- Grantham and District Hospital (not being inspected in this current inspection)

Trust data in this appendix will cover all three locations but data will only be split down to location level for Lincoln County Hospital and Pilgrim Hospital – the two hospitals to be inspected.

(Source: Trust Routine Provider Information Request)

Lincoln County Hospital provides consultant led emergency care and treatment 24 hours a day, seven days a week to people across Lincoln and North Lincolnshire area.

The department has 15 majors’ cubicles, six minors’ cubicles, one eye treatment room, four resuscitation spaces, one triage room, a plaster room, and designated waiting rooms for adults and paediatric patients. There was also a quiet room for relatives to utilise whilst waiting for news and a room which was for patients with mental health conditions. There was a five bedded Rapid Assessment and Treatment area (RAT) plus one assessment cubicle which are available within the main department between 10am and 10pm.

There was an ambulatory care unit which had six trolleys, one side room and a separate waiting area which had been moved away from the main accident and emergency department. This was open from 8 am until 10 pm.
Lincoln County Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.

**Activity and patient throughput**

**Total number of urgent and emergency care attendances at United Lincolnshire Hospitals NHS Trust compared to all acute trusts in England.**

There were 156,761 attendances from April 2016 to March 2017 at United Lincolnshire Hospitals NHS Trust as indicated in the chart above.

*(Source: NHS England)*

From April 2017 to February 2018 there were 66,586 emergency attendances at Lincoln County Hospital. Of these attendances, 11,360 (17.1%) were paediatric patients.
The percentage of A&E attendances at this trust that resulted in an admission increased from 2015/16 to 2016/17. In both years rates were higher than the England average by 3.6% and 5.1% respectively.

(Source: NHS England)

The graph above shows data for October 2016 to September 2017.

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 90% for completion of the majority of mandatory training, however some modules had a higher target which can be seen in the table below.

A breakdown of compliance for mandatory training courses from April 2017 to October 2017 for medical/dental staff in urgent and emergency care is shown below:

Lincoln County Hospital – medical / dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>12</td>
<td>10</td>
<td>83</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>12</td>
<td>10</td>
<td>83</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>12</td>
<td>10</td>
<td>83</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>12</td>
<td>9</td>
<td>75</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>12</td>
<td>9</td>
<td>75</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>12</td>
<td>6</td>
<td>50</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>12</td>
<td>6</td>
<td>50</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>12</td>
<td>5</td>
<td>42</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>12</td>
<td>4</td>
<td>33</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>12</td>
<td>4</td>
<td>33</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>12</td>
<td>3</td>
<td>25</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

At the time of reporting the trust was not meeting the 90% target in any of the mandatory training modules for medical and dental staff at Lincoln County Hospital.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and health visiting staff in urgent and emergency care is shown below:

Lincoln County Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud Awareness</td>
<td>77</td>
<td>75</td>
<td>97</td>
<td>95</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>77</td>
<td>74</td>
<td>96</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>77</td>
<td>74</td>
<td>96</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>77</td>
<td>71</td>
<td>92</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>77</td>
<td>64</td>
<td>83</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>
At the time of reporting the Lincoln County Hospital was not meeting the 90% target in six out of the 11 mandatory training modules for qualified nursing and health visiting staff.

(Source: Routine Provider Information Request (RPIR) – Training)

Lincoln County Hospital- Support to doctors and nurses staff.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of qualified nursing staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud Awareness</td>
<td>51</td>
<td>44</td>
<td>86</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>51</td>
<td>50</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>51</td>
<td>48</td>
<td>94</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>51</td>
<td>49</td>
<td>96</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>51</td>
<td>42</td>
<td>82</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>51</td>
<td>47</td>
<td>92</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>51</td>
<td>38</td>
<td>75</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>51</td>
<td>41</td>
<td>80</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>51</td>
<td>35</td>
<td>69</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>51</td>
<td>39</td>
<td>76</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>51</td>
<td>19</td>
<td>37</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

At the time of reporting the Lincoln County Hospital was meeting the trust target for mandatory training for four out of 11 modules for support to doctors and nurses staff.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of qualified nursing staff</th>
<th>Number of medical staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Life Support (ALS)</td>
<td>31</td>
<td>17</td>
</tr>
<tr>
<td>European Paediatric Advanced Life Support (EPALS)</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Immediate Life Support (ILS)</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>Paediatric Immediate Life Support (PILS)</td>
<td>22</td>
<td>4</td>
</tr>
</tbody>
</table>

Updated information from the trust showed most qualified nursing staff in the emergency department had life support training more advanced than the basic level for adult patients. Senior staff told us however, staffing rota (medical and nursing) ensured there was sufficient member of
staff with a more in depth paediatric life support qualification on shift always. Information for medical staffing showed the majority of staff held an ALS qualification for adult life support.

Staff received training on sepsis identification and management including the use of sepsis screening tools and the use of specific care bundles through an electronic package. At the time of our inspection, 88.7% of qualified nursing and health visitor staff had completed this training. This was slightly worse than the trust target of 90%.

There was a rolling training programme in place for staff caring for patients with mental health, learning disabilities, autism and dementia. We requested the staff to provide the number of staff who had completed this training, however this was not provided with the specified timescale.

**Safeguarding**

The director for nursing had the overall responsibility for safeguarding with support from the deputy director of nursing. There were trust wide named nurses for adult and children safeguarding, as well as a named doctor which staff were aware of. Policies, procedures, protocols and frameworks were readily available for staff to use, and staff knew where to locate these.

Staff from the department made 11 safeguarding referrals during the period of November 2016 to October 2017. Staff told us they felt confident in raising concern about a child or vulnerable adult and would regularly contact the safeguarding department if they wanted to discuss a patient.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training from April 2017 to October 2017 for medical/dental staff in urgent and emergency care is shown below:

**Lincoln County Hospital – medical / dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>12</td>
<td>6</td>
<td>50</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>12</td>
<td>6</td>
<td>50</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>12</td>
<td>6</td>
<td>50</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>12</td>
<td>6</td>
<td>50</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>12</td>
<td>6</td>
<td>50</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for any of the safeguarding training modules for which medical and dental staff were eligible at Lincoln County Hospital.

A breakdown of compliance for safeguarding training from April 2017 to October 2017 for qualified nursing and health visiting staff in urgent and emergency care is shown below:
Lincoln County Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>77</td>
<td>76</td>
<td>99</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>77</td>
<td>76</td>
<td>99</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>58</td>
<td>55</td>
<td>95</td>
<td>90</td>
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<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>77</td>
<td>72</td>
<td>94</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>77</td>
<td>72</td>
<td>94</td>
<td>90</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all safeguarding training modules for which qualified nursing and health visiting staff were eligible at Lincoln County Hospital.

(Source: Routine Provider Information Request (RPIR) Training)

Lincoln County Hospital- Support to doctors and nurses staff.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>51</td>
<td>45</td>
<td>88</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>51</td>
<td>45</td>
<td>88</td>
<td>90</td>
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</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>46</td>
<td>37</td>
<td>80</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>48</td>
<td>39</td>
<td>81</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>48</td>
<td>39</td>
<td>81</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for any of the safeguarding modules for which support to doctors and nurses staff were eligible for at Lincoln County Hospital.

Although compliance did not meet trust targets for all staff groups on all aspects of training, we found staff we spoke with understood how to identify and protect patients from abuse. Staff were aware of their roles and responsibilities around safeguarding and knew whom to contact for help and advice if required.

Staff were aware of the safeguarding issue of child sexual exploitation (CSE). This was part of their safeguarding training and staff felt confident in identifying children who were at risk. The electronic system used recorded an alert for a patient where they had a CSE risk assessment completed on them. Since October 2016, the trust had reported two cases of potential CSE cases.

The department had developed an aid for helping staff identify patients who were a potential safeguarding risk. The yellow ‘SAFER’ sticker was present in all department notes and this was based on the SAFER communication brief which was issued by the Department of Health. Although this had initially been developed for paediatric safeguarding concerns, staff told us they used them for all patients now as it was useful to focus on any potential safeguarding issues. During our inspection we saw staff using the SAFER sticker well.

An audit on safeguarding practices was completed by the safeguarding team quarterly. Part of this audit reviewed the use of the SAFER sticker. The audit completed in quarter three (October-
December 2017 reviewed 15 records, 10 records had the SAFER sticker completed for children and young people admissions. This was a reduction from the results of the audit in quarter two. We asked the trust to provide further information about this audit, however the information provided did not provide the specific information requested. Other areas covered in the audit included escalation to external agencies and whether this was appropriate (nine out of the 10 records applicable detailed appropriate escalation) and evidence of the ‘child’s voice’ being listened to and considered (13 out of the full 15 records demonstrated this).

There was a system in place which indicated to staff when a child was known to social services for safeguarding reasons or if they were frequent attendees to the department. Staff were aware of this system and could indicate where this would be found if an alert was associated to a record.

Staff had completed Prevent and WRAP (workshop to raise awareness of Prevent training) training as part of their safeguarding training. Prevent training is aimed at safeguarding people from radicalisation and extremism, and preventing people becoming involved in terrorism. Although staff had an awareness of prevent, at the time of our inspection they had not had to escalate any concerns in relation to this.

Staff told us Female Genital Mutilation (FGM) was part of the safeguarding training they received and all staff demonstrated a sound understanding of this. FGM is defined as the partial or total removal of the female external genitalia for non-medical reasons. Staff told us they would feel confident in identifying a case of FGM and knew the process for reporting a case. Information provided by the trust showed 28 cases had been reported since October 2016. Of these reported cases, the majority of these were in relation to piercings.

Staff had an awareness of the Mental Health Act S5(2) doctors holding powers, however they were less aware of the S5(4) nurses’ holding power. Staff told us they would urgently seek support from the mental health team for any patients who required this input, especially those who would require to be held for safety purposes.

There was a chemical restraint policy in place for patients who would require this treatment. When staff used this method of restraint, a register of patients’ names was kept and this was audited by the safeguarding team.

### Cleanliness, infection control and hygiene

The department was visibly clean and tidy at the time of our inspection. The cleaning service within the department was 24 hours a day which helped to maintain a clean department. Information provided by the trust before the inspection showed the department had variable levels of compliance with cleaning audits. For the period of February 2017 to January 2018 the department scored an average 76.8% compliance with their local cleaning audits, with a range of 56.8% in July 2017 to the highest of 86.6% in May 2017. This was worse than the trust target of 95%. The department had not met the target for any of the 12 months and had only completed action plans for five of the 12 months. Cleanliness issues identified through these audits included general dust and dirt around the department as well as bodily fluids left on equipment and food deposits found in microwaves and refrigerators.

In the 2016 CQC national Emergency Department survey, the trust scored ‘about the same’ as other trusts when patients were asked about the cleanliness of the department.

There was a trust policy for staff to follow for controlling and preventing infection. Staff were aware of this policy and we saw evidence of staff following best practice as well as challenging other staff who were not adhering to trust policies. During our inspection, we observed staff from the
department challenging other members of staff who visited the department about their standard of dress, in particular the bare below elbow standard.

The department had adequate provision of hand washing facilities for staff to use, as well as the provision of hand gels at the point of care. All cubicles and side rooms had a clinical hand washing sink which conformed with Health Building Note 00-09 infection control in the built environment. Information provided by the trust for the period of February 2017 and January 2018 showed the department had compliance levels between 93% and 100%. We observed staff mainly adhering to the five moments for hand hygiene (World Health Organisation) during our inspection with the occasional missed opportunity before putting on a pair of gloves to provide care and treatment. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene to reduce risk of cross contamination between patients.

Staff had an awareness of patients admitted with potentially infectious diseases. In the admission documentation, there was an IPC risk assessment which staff conducted. There were also posters within the department which highlighted to patients the importance of informing staff if they had recently travelled abroad and had also received healthcare abroad. There were side rooms within the department where patients at risk of an infectious disease could be nursed which reduced the risk to other patients. During our inspection, we observed staff identifying potentially infectious patients and caring for them in side rooms. Additional personal protective equipment was placed outside to remind staff of the requirements for taking additional precautions when providing care and treatment.

The department monitored the care received by patients who had a urinary catheter and who had a peripheral cannula as part of the safety and quality dashboard (SQD). A urinary catheter is a tube inserted into a patient's bladder to allow drainage of urine. A peripheral cannula is a small tube inserted into a vein to allow the administration of medicines. Both can be associated with increased risk of infections for patients. For the period of November 2016 to October 2017 the department recorded five urinary catheters had been inserted and all aspects of care had been completed (recorded demographics correctly, documented reasons for insertion and catheter bag secured). For the same period the department recorded 24 peripheral cannula insertions. All 24 peripheral cannulas had recorded evidence of the cannula being labelled correctly and visual infusion phlebitis charts completed, however for five months (March, April, June, August and September 2017) only 50% of the cannulas inserted had the required demographic information completed on the VIP chart. During our inspection, we reviewed three VIP charts and found all elements had been completed.

All staff who completed venepuncture and cannulation, as well as the qualified staff who provided intravenous therapy (fluids or medication through a vein) completed aseptic non-touch technique (ANTT) training. ANTT is a standardised approach to performing an aseptic technique for invasive procedures, reducing the risk of a healthcare acquired infection (HCAI). During our inspection we observed staff demonstrating variable compliance with ANTT. We observed staff preparing an intravenous injection not protecting the key parts (tip of a syringe) and using papier-mâché trays which could not be decontaminated (cleaned) before use. This meant there was a potential for equipment to become contaminated before procedure which could then be transmitted to a patient. This was discussed at the time with staff members involved.

We found all equipment reviewed was visibly clean and the department used the 'I am clean' system to identify when items had been cleaned. We observed a plentiful supply of decontaminating wipes around the department to support staff with maintaining the cleanliness of equipment. We also observed staff decontaminating equipment in between patient use.
Environment and equipment

The department had one triage room, six minors’ cubicles, 15 majors’ cubicles (one of these cubicles was currently used for four ‘fit to sit’ patients), a four-bedded resuscitation (resus) room, a plaster room, three rapid assessment and treatment (RAT) cubicles, a relative’s room, a mental health designated room and a large waiting room. There was also an additional ambulatory care unit which had six trolleys and a side room as well as a dedicated imaging department which provided X-rays. The department was within a short distance to theatres; further imaging requirements including computerised tomography (CT) and the hospital helipad.

There was a card operated door between the main waiting area and the major’s cubicles, which had a door bell for visitors wanting to visit patients. However, further down the corridor near to where the plaster room was, there was a set of doors which were open at all times whilst we inspected the department. This meant there could have been unpermitted entrance to and exit from the department as this area was not always observed by staff.

We reviewed 18 items of equipment in the department. All items had evidence of an in-date service and electrical safety test. Staff were aware of the process for reporting items of equipment which were broken or not working appropriately.

The department audited their own compliance with resuscitation equipment checking as part of their safety and quality dashboard (SQD). Information provided by the trust for the period of November 2016 to October 2017 showed there were four months (December 2016, March, August and October 2017) when they did not meet the target for the required checks. During our inspection we reviewed two resuscitation trolleys (one in majors and one in resus department). We found the resuscitation equipment in the yellow area of the majors’ department had been checked consistently from November 2017 up to and including the date of inspection (14 March 2018). However, we found the resuscitation equipment in resus had not been consistently checked during the same time. Where we found gaps (five days in December, four days in January and one day in February) there was a note to indicate that action had been taken to address this. This was identified on the previous inspection in 2016 as an issue in regard to consistent checking. Although there appears to have been improvements made, the department were still failing to consistently check this vital equipment. Both resuscitation trolleys had tamper proof seals in place.

There was a difficult airway trolley (DAT) located in the resus room. This provided additional equipment for staff to use in the anticipation of managing a difficult airway. We found this was regularly checked and a tamper proof seal in place when not in use or recently been used.

During our previous inspection in 2016, we were not assured that the environment for patients presenting with mental health concerns, in particular suicidal or self-harming intentions was appropriate and staff knowledge around ligature points (anything which can be used to attach cord, rope or other material for the purpose of hanging or strangulation) and the provision of ligature cutters was limited. We requested for the trust to share further information about how they would address our concerns after this previous inspection. During this inspection we found staff had a suitable knowledge around mental health concerns and ligature points and were able to locate ligature cutters in the department. Senior staff from the department were also in the process of refurbishing a room in the department to meet PLAN (Psychiatric Liaison Accreditation Network) standards. This room was currently used for the assessment of patients presenting with mental health concerns, however it was acknowledged there were issues with the room at the time of this inspection, which included the door opening inwards instead of outwards. Staff had risk assessed the use of this room in its current condition for the assessment of mental health patients. We requested a copy of the risk assessment after the inspection, however the documents forwarded.
were not specifically for the room identified at this location, they were for the room in the emergency department at Pilgrim hospital.

There was a dedicated waiting area for paediatric patients which was situated close to where the minors’ cubicles were located. When the door was closed, this did provide an audio and visual separation from the main waiting area, however as the area was compact, we did not observe the door being closed whilst in use, and also observed most children opting to wait in the main waiting area. Paediatric patients who did use this designated area still had to use the main entrance and pass adult patients to get to this room. Although it was acknowledged that staff from the department had try to address the same concern identified in the previous inspection, the current arrangement still did not completely meet the standards of the Intercollegiate Committee Standards for Children and Young People in Emergency Care Settings (2012). The paediatric waiting room had items in there which would occupy younger children, however we did not observe any items which would be suitable for older children.

Within the majors department, there was one cubicle which had been identified as a paediatric cubicle and one of the bays in resus had also been identified as a paediatric resus bay. There was some decoration within both areas to designate this as a paediatric area, however this was minimal. The Intercollegiate standards recommend that a designated cubicle or trolley should be made available per 5,000 paediatric admissions. Information provided by the trust showed in the last 12 months, there were over 11,000 paediatric admissions during this period which meant there should have been two cubicles identified for paediatric patients. Senior staff were aware more could be done to meet the standards and were in the process of reviewing what additional measures could be put in place. During our inspection, we observed several paediatric admissions in the department, both in the majors department and resus room; however paediatric patients were not admitted into the relevant paediatric cubicle/resus bay during this time.

We reviewed a selection of 20 consumable items in the department which included blood bottles, cannulas, needles, syringes and dressings and found all items to be in date.

We observed clinical and domestic waste was correctly segregated and waste bins provided for the department were compliant with health technical memorandum (HTM) 83 as they were fire retardant as well as being enclosed and foot operated which are requirements under the larger waste management guidance document HTM 07-01 safe management of healthcare waste. The management and disposal of sharps was completed in accordance with trust policy.

Assessing and responding to patient risk

Emergency Department Survey 2016

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>7.2</td>
<td>About the same as other</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.3</td>
<td>About the same as other</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait</td>
<td></td>
<td>trusts</td>
</tr>
</tbody>
</table>
you wait before being examined by a doctor or nurse?

Q33. In your opinion, how clean was the emergency department?

| 8.3 | About the same as other trusts |

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?

| 9.5 | About the same as other trusts |

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

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was worse than the overall England median over the entire 13-month period from November 2016 to October 2017.

From November 2016 to March 2017 the median time to initial assessment was between 24 and 26 minutes compared to the England average of seven minutes. From April 2017 to October 2017 the trust’s median time to initial assessment fell considerably to nine to ten minutes each month. This was much closer to the England average of seven minutes.

**Ambulance – Time to initial assessment from November 2016 and October 2017 at United Lincolnshire Hospitals NHS Trust**

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

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

**Lincoln County Hospital**

From December 2016 to November 2017 the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Lincoln County Hospital decreased from March 2017 and July 2017 but the percentage increased again from August 2017 to November 2017. The percentage of these 30-minute journeys that were over 60 minutes varied over time from 18.9% in July 2017 to 38.3% in February 2017.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Lincoln County Hospital**
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Lincoln County Hospital

(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From November 2016 to October 2017 the trust reported 5,909 “black breaches”, with a variable trend over time, which can be seen in the graph below.

The number of “black breaches” reported on a weekly basis ranged from 36 to 239. In the most recent reported month the number of “black breaches” ranged from 79 to 221. The trust noted that work done earlier in the year to open a new Rapid Assessment and Treatment (RAT) area at Lincoln did have a significant effect with reducing delays. However, later in the year, from October onwards, delays began to increase again. This coincided with increasing demand and a new electronic handover system from the local ambulance service. It has been reported that the system suffers from faulty terminals and difficulties connecting to 3G - crews report having to go back to base before being able to download handover forms. Work was in progress with the local ambulance service to improve this situation.

(Source: Routine Provider Information Request (RPIR) AC12a – Black Breaches)

There was an effective streaming and triage system in place within the department for patients
arriving at the front door. Streaming is defined as the process of allocating patients to different areas, services, pathways or processes to improve efficiency and effectiveness (Royal College of Emergency Medicine (RCEM)). A senior nurse was located alongside the reception staff who booked them in. This allowed the nurse to have oversight of the patients presenting complaints and therefore identify which pathway the patient would require through the department. This also enabled the nurse to identify any patients who required immediate escalation to the majors’ cubicles or resus. Streaming nurses used an evidence based tool to ensure that patients were prioritised in line with their presenting condition.

Primary healthcare streaming was also available at this location. Patients who were deemed appropriate were seen by staff from a local community NHS trust who had strict criteria for the patients they saw. During our inspection we observed one patient streamed through the primary healthcare route. After assessment by the GP on duty, the patient was referred back to the ED department for diagnostic imaging.

The Royal College of Emergency Medicine (RCEM) ‘Initial assessment of emergency department patients’ suggests a detailed triage assessment should be made within 15 minutes of the patient’s arrival. We reviewed 24 patient records and found 19 patients had been triaged on their initial arrival at the hospital. We found staff were not always meeting RCEM guidance for triage times, with times being recorded between zero minutes to 120 minutes (average 22.5 minutes). Our records showed 10 patients had been triaged in 15 minutes or less, five patients triaged between 16 to 30 minutes, two patients triaged 31 to 60 minutes and two patients triaged above 60 minutes after they arrived. Of the five other patient records reviewed, it was documented that triage was not required for four of these and one patient was brought into the department by ambulance. Staff used a recognised tool for triaging patients (Manchester Triage tool) this helped staff to identify the priority of which patients needed to be seen.

The department monitored their own triage times as part of their monthly safety and quality dashboard (SQD). Information received before the inspection showed from November 2016 to October 2017 an average of 62.9% of patients were triaged within the 15 minutes, with results ranging between 22.2% (recorded in September 2017) to 100% (recorded in July 2017).

The trust used an emergency department risk assessment tool which calculated the risk of the department and used a red, amber and green (RAG) rating for the level of risk. This required staff to input information on an hourly basis and we saw an effective use of this tool. Information from this tool was used at operational meetings to enable the executive team to implement plans to manage the service. During our inspection, we attended an operational meeting when pressures on the department were high and observed the executives taking steps to manage the pressures experienced within the department. At the time of the meeting (10.30am), the department reported there were 59 patients in the department with 12 patients waiting beyond the 12 hours after the decision was made to admit the patient (DTA) and the average triage time was recorded as 20 minutes.

Patients brought into the department by ambulance were brought into the corridor outside the resus room. During the hours of 10 am to 10pm, crews were redirected to the rapid assessment and treatment (RAT) area. Outside of these hours, crews would wait in the corridor until handover could be completed. We reviewed 17 records of patients brought into the department by ambulance during our inspection. Handover times ranged from zero minutes to 133 minutes, with only three patients being handed over within the recommended 15 minutes. Staff told us there had recently been significant delays with ambulance handovers, with some crews waiting up to four hours to hand patients over to the ED staff. The RAT area had been opened for six months and...
had varying success at reducing the ambulance handover times. At the time of our inspection, we did not observe any handover delays in the RAT area.

During the week of our inspection (12 March to 18 March 2018) information received from the local NHS ambulance trust showed 496 ambulances attended Lincoln County emergency department between this times. Of these attendances, 377 (76%) of ambulance handovers were over the recommended 15 minutes. The information provided showed 137 (36.3%) were delayed between 30 to 59 minutes, 64 (17%) were delayed between 60 to 120 minutes and 25 (6.6%) were delayed between 120 to 240 minutes. No ambulance crews were delayed for any longer than four hours.

We observed an effective system in place for managing patients who were waiting in the corridor to be handed over to the ED staff. A standard operating procedure (SOP) had been developed by the staff in the department and the local ambulance trust for the management of these patients. Until the patients had been handed over to the ED staff, ambulance crews would monitor the patients and record observations as directed by the SOP and report to the co-ordinator of the department regularly. If a patient was showing signs of deteriorating, this was immediately communicated by the ambulance crews to the ED co-ordinator and they would respond to this information appropriately. During our night visit to the department, we observed ambulance crews escalating a patient to the co-ordinator who they had identified had deteriorated since their arrival. The co-ordinator prioritised them ahead of two other patients to the next available cubicle so they could be urgently assessed by the medical team.

Staff used the national early warning scoring system (NEWS) and a paediatric early warning scoring system (PEWS) when carrying out physiological observations (blood pressure, pulse, oxygen saturations, temperature and respiratory rate). An early warning score is a guide used by healthcare staff to quickly determine the degree of illness of a patient and prompts support from medical staff and/or senior nursing staff when required. Staff told us they had recently changed from paper based observation charts to an electronic observations system which automatically calculated a patients NEWS or PEWS and then indicated a red, amber or green (RAG) risk to the patient. This would also prompt the staff member as to the response which was required, including the frequency of repeating the observations. A large television screen was present in the majors cubicle area which displayed the NEWS or PEWS scores for patients; this also indicated when observations were due again. Staff told us this was useful as it gave all staff members an 'at glance' view of the patients degree of illness and also indicated if the patient's condition was improving or deteriorating.

The new electronic observations system also identified when a patient required screening for sepsis. Staff told us any patient who had a NEWS score of five or above would require screening for sepsis. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs. During our inspection in October 2016, we issued a requirement notice to the trust with specific requirements to improve the identification and treatment of patients with sepsis. During this inspection (March 2018) we reviewed 20 observation charts and found four patients with a NEWS of five or above. All four patients had been screened for sepsis, with only one patient screened positive for sepsis and were commenced on the sepsis bundle. A sepsis bundle or sometimes known as ‘the sepsis six bundle’ refers to key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of ‘basic’ aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour. We reviewed the notes of the patient who screened positive for sepsis and found all elements of the bundle had been completed well within the first hour. This was an improvement from our findings in the previous inspection. Monitoring of sepsis performance was
part of the SQD which was completed by the department. Information provided before the inspection showed from November 2016 to October 2017, the department had completed sepsis screening for 91.7% of the patients with a NEWS score of five or above however the full sepsis six bundle had only been completed within an hour for 66.7% of the patients. The information provided by the trust showed there was missing data for sepsis performance. Four months’ worth of data was missing for the number of patients screened for sepsis after scoring a NEWS of five or above and six months’ worth of data was missing for performance on initiating the sepsis six bundle. We therefore could not be assured the department were identifying all patients for sepsis and implementing the sepsis six bundle in a timely fashion for all patients within the department.

There was a paediatric emergency response team (PERT) within the hospital which staff contacted in the event of a deteriorating child to attend the department. If there was a seriously ill child on route to the department, staff would contact the PERT team to pre-alert them. There were also staff members within the department with deteriorating child competencies as well as staff who was dual trained (registered adult nurse and registered children’s nurse) who could provide care and treatment to paediatric patients until the PERT team arrived. Staff told us if the PERT team were required or if they wanted some advice from the registered children’s nurses on the paediatric wards, they were very responsive and helpful. If they have required someone to attend the department, they could not recall a time when this did not happen.

There was a screening tool in place for staff to use when assessing the risk of physical abuse to children who visited the department. Staff were aware of these screening tools and would contact safeguarding and the paediatricians for additional advice and support if required.

There was access to mental health teams for the full 24 hour period. Mental health liaison teams were available between 8am and 10pm and the mental health crisis team was available between 10pm and 8am. Staff told us both teams were very responsive to referrals, with the liaison team attending the department within an hour of referral. Contact numbers were made easily available for staff members to use. During our inspection we observed staff referring a patient to the mental health liaison team. At the time of our inspection, the room identified as a place of safety for patients with mental health concerns did not meet the specifications required, however the trust was in the process of adapting this room to meet the requirements.

All patients who were admitted into the department were required to have an assessment of their pressure areas conducted using a recognised tool (Anderson tool). Staff told us if patients scored two or more, a more in-depth assessment would be completed and actions taken in response to the outcome of the risk assessment. We reviewed 24 patient records and found the assessment had been conducted in 21 of these notes. Of these 21 assessments, there was no evidence of patients requiring additional, more in depth assessment. We also observed in all records evidence of hourly intentional rounding on patients to ensure they were comfortable.

Medical staff from the department had devised a risk assessment tool to help identify patients attending the department with symptoms of aortic dissection. Staff told us patients attending the department with chest pain would have a sticker placed on their notes that had the pneumonic ‘Trueman Show’ on this to help identify if the patient actually had an aortic dissection (tear in the wall of the main artery in the body which carries blood away from the heart). The Trueman Show stands for tearing pain, recreational drug use, unequal blood pressure, Marfans syndrome and other genetic disorders, aortic valve disorder, neurology, syncope, hypertension, onset sudden and weird mediastinum. All these criteria were associated with this condition, if a patient presented with two or more of these criteria, furthermore in-depth assessments and investigations would be required.
We observed staff escorting patients who required close supervision to the imaging department or on transfer to the wards. Staff ensured those in the department were aware of their imminent absence from the department and there was appropriate cover for them whilst they were absent. During our night visit to the department, we observed the site manager helping with patient escorts to admitting wards to help the staff in the department.

**Nurse staffing**

The trust reported their registered nursing staff numbers, as of October 2017, as shown below. For all sites there were 230.4 WTE planned staff and 230.0 in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>69.2</td>
<td>67.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

The trust reported their unregistered staff numbers for the department as shown below.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>27.7</td>
<td>21.5</td>
</tr>
</tbody>
</table>

**Vacancy rates**

From November 2017 to October 2017 the trust reported a vacancy rate of 19.8% for nursing and midwifery staff in urgent and emergency. The vacancy rate for this site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>11.5</td>
<td>11.3</td>
</tr>
</tbody>
</table>

Vacancy rates at Lincoln County Hospital were below the trust target.

(Source: Routine Provider Information Request (RPIR) Vacancy)

**Turnover rates**

From 30 November 2016 to 31 October 2017 United Lincolnshire Hospital reported an annual turnover rate of 5.2% for nursing and midwifery staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate for this site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>1.9</td>
<td>3.0</td>
</tr>
</tbody>
</table>

The turnover rate for nursing staff at both sites was below the trust voluntary target of 7%.

(Source: Routine Provider Information Request (RPIR) Turnover)
Sickness rates

From October 2016 to September 2017 United Lincolnshire Hospital reported a sickness rate of 5.5% for nursing staff in urgent and emergency care. The trust’s target rate for sickness is 4.5%.

A breakdown for this site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Sickness rates for qualified nursing and health visiting staff from October 2016 to September 2017 were above the trust’s target at Lincoln County Hospital.

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

Bank and agency staff usage

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 17.7% with a further 4.6% of shift remaining unfilled. A breakdown by staff type is shown below:

Lincoln County Hospital

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>1,795 (10.0%)</td>
<td>778 (4.3%)</td>
<td>394 (2.2%)</td>
<td>17,974</td>
</tr>
<tr>
<td>Unregistered</td>
<td>3 (0.0%)</td>
<td>994 (14.8%)</td>
<td>229 (3.4%)</td>
<td>6,735</td>
</tr>
</tbody>
</table>

At the time of our inspection, the department had 74 qualified nurses in post and 13 WTE vacant posts which they were actively recruiting into (March 2018). The department did not use any tools to identify what the establishment for the department would be. Senior staff told us they had previously used the BEST tool to try and calculate an establishment for the department, however the results were not feasible due to the large number of staff this suggested was required.

Each shift had a designated band six nurse who co-ordinated the department in a supervisory capacity. Between the hours of 10am to 10pm, there was also a flow co-ordinator who was responsible for ensuring there was efficient flow through the department and would chase up referrals and investigations patients may be waiting for. Although the flow co-ordinator had a clinical background, they would not be responsible for any clinical care during their shift.

Staffing for each shift was based on knowledge of when peak demand for the department occurred. Senior staff told us they planned for 10 qualified staff on an early shift, 11 qualified staff on a late shift and eight qualified staff (including two band six nurses) on a night shift. Senior staff told us intelligence suggests an uplift in the number of qualified staff for the night shift is required to take this up to 10 qualified staff members, however due to the vacancy rate; this could not be accommodated at the time. In addition to the qualified staff members, five unqualified staff (band two healthcare assistants) were required in the daytime and two unqualified staff members required during the night. We found the staffing levels and skill mix during our inspection was sufficient to meet the needs of the patients, with staff being responsible for no more than four patients at one time.

We reviewed the planned staffing against the actual staffing for the four weeks leading up to our inspection. We found out of 28 days, there were only four days where all shifts were staffed to the...
planned requirements. There were 12 days when the shifts were down either one qualified member of staff or one unqualified member of staff. On the remaining 12 days, it was calculated that two or more qualified or unqualified staff members were absent from the shift. Senior staff told us with the current levels of staffing they were just managing to meet the requirements of the department, however the past 28 days had seen significant challenges due to short term sickness and inclement weather conditions which made it difficult for staff to make their way to the hospital.

At the time of our inspection the department had two nurses who were dual trained in adult and children’s nursing with an additional one member of staff on secondment to complete their course and another one waiting to go on their training. This meant the department could not meet the Royal College of Nursing (RCN) guidance: defining staffing levels for children and young people’s services and RCEM emergency department care guidance which states one registered nurse (children) should be on each shift in a mixed emergency department. However, the department had attempted to mitigate this risk by ensuring all band six nurses completed competencies in the management of a sick or injured child, as well as completing the European paediatric life support training (EPLS). This ensured that on each shift there would be at least one member of staff who not only had more advanced paediatric life support training than other staff, but also the knowledge of identifying when a paediatric patient was deteriorating. We reviewed the planned and actual staffing for the four weeks leading up to our inspection and found there was at least one member of staff on each shift who held paediatric competencies and a more advanced paediatric life support qualification.

There was a protocol in place to ensure all agency and bank staff had a local induction into the emergency department before they began work. During our inspection we observed one agency staff member working in the department and they could demonstrate they had been inducted locally. Staff told us they had regular agency staff who completed shifts in the department; this was beneficial for the department as they were aware of the policies, procedures and guidelines for the department, as well as knowing about the local layout of the department. We also observed bank staff working in the department who could demonstrate they had been inducted locally and had evidence of all their mandatory training which they shared with the trust.

There were two handovers which took place each day (7.45am and 7.45 pm). These were combined handovers which both medical and nursing staff attended. In addition to these handovers, staff also had safety huddles which they attended. These took place at 8am and 8pm and discussed important safety issues which could impact on the shift.

There was a team of 15 advance care practitioners (ACPs) who worked across the urgent and emergency care core service. They were led by a consultant nurse and a lead ACP. ACPs are clinical professionals who have developed their skills and theoretical knowledge to a very high standard and are able to carry out tasks like that of a junior doctor. The ACPs mainly worked in the ambulatory care unit, which was open between 8am and 10pm.

**Medical staffing**

The trust reported their medical & dental staff numbers as below as of October 2017. For all sites there were 85.2 WTE planned staff and 53.8 in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>37.2</td>
<td>22.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)
Vacancy rates

As of October 2017, the trust reported a vacancy rate of 32.2% for medical and dental staff in urgent and emergency. The vacancy rate for this site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>12.0</td>
<td>37.9</td>
</tr>
</tbody>
</table>

Lincoln County had a much higher vacancy rate than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) Vacancy)

Turnover rates

From 30 November 2016 to 31 October 2017 United Lincolnshire Hospital reported an annual turnover rate of 8.8% for medical and dental staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate for this site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Sickness rates

From October 2016 to September 2017 United Lincolnshire Hospital reported a sickness rate of 6.6% for medical and dental staff in urgent and emergency care. The trust’s target rate for sickness is 4.5%.

A breakdown for this site and staff group can be seen below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>8.2</td>
</tr>
</tbody>
</table>

The sickness rate for medical and dental staff from October 2016 to September 2017 was above the trust’s target at this site.

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

Staffing skill mix

For August 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher.
Staffing skill mix for the 48-whole time equivalent staff working in Urgent and Emergency Care at United Lincolnshire Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>33%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>10%</td>
<td>35%</td>
</tr>
<tr>
<td>Junior*</td>
<td>32%</td>
<td>23%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

There were four substantively employed consultants that worked in the department, one of which was the head of service. An additional three locum consultant supported the department. Consultant cover for the department was 14 hours (physical) from 8am until 10pm each day. However, during our inspection consultants told us that they often covered until 12pm and would not leave the department unless it was safe to do so. Between 10pm until 8am there was an on-call consultant. This meant the department did not meet the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours of physical consultant cover per day. During our previous inspection, we identified that the department was not meeting the 16 hours of physical consultant cover in the department and advised them to ensure staffing was adapted to meet this recommendation by RCEM. We discussed this with the head of service, who told us that once the department had met his establishment, they could provide 16 hours cover.

One consultant would be designated as the emergency physician in charge (EPIC) each day. The EPIC was responsible for ensuring patient flow from a medical point of view and would ensure all patients had plans in place by the medical staff. In the event of pressures building up in the department, they would discuss with the nurse in charge (shift co-ordinator) what escalation plans they could implement.

There was physical 24-hour cover in the department by the middle grade and junior doctors. The department also had foundation year one (FY1) doctors working there as part of their rotation. FY1 doctors worked between 8am and 6pm.

Medical staff attended the handovers which were combined with the nursing staff twice a day. These were held at 7.45am and 7.45pm. No additional medical handovers took place unless pressures within the department escalated and additional huddles/handovers would be conducted between the EPIC and nurse in charge.

All locum staff attended the trust induction before they started work in the department. This was recorded on the trust system. If additional mandatory training was required to what they already
had, they would attend the training held by the trust. Pre-employment checks of locum doctors was performed by the trust human resources team.

There was no consultant in the department who had any sub-speciality of paediatric emergency medicine. However, each day, one consultant would be designated as the consultant with paediatric responsibility. If further speciality advice was required, especially in the event of a SUDIC case (sudden, unexpected deaths in infancy and childhood) they would request assistance from a paediatrician. During our inspection, we observed a paediatrician attending the department to review a patient in a timely manner.

Records

Patient records were paper based and completed by all members of the multidisciplinary team. When not in use, the patient records were kept in designated trays at the staff station. There were boxes for patients who required assessment, patients who required a review and a designated paediatric box for paediatric patients who were waiting in the waiting room to be seen. Although these boxes were not locked away, during our inspection we observed that there were always staff around this area to ensure records were not accessible to unauthorised individuals. We also observed staff members challenging people who were close to this area, who they did not recognise to ensure records remained confidential and inaccessible to unauthorised people.

Patients who were brought into the department by ambulance had electronic patient record forms which could be printed off and attached to their department notes. Staff told us they did not always request for the ambulance staff to print off the notes unless there were significant details contained within them.

We reviewed 24 patient records during our inspection. We found records were generally well maintained with entries which were timed, dated, signed and name and designation printed. We observed some staff members used personal stamps to record their professional details when completing patient records. We requested a copy of the latest documentation audits, however we did not receive these.

Patient records were the same for both adult and paediatric patients admitted into the department. Staff would use a blue sticker to identify the patient was paediatric. There were also paediatric sepsis screening tools and observation charts which were available in paper format, however the new electronic observation tool was adapted to ensure this would also capture paediatric patients.

Staff told us there was a plan to update the patient records booklet to ensure the patient safety checklist was completed. At the moment, staff had to stick the checklist into the booklet. Of the notes we reviewed, we found evidence of staff completing the checklists in all notes.

In 21 of the 24 notes we reviewed, we found evidence of staff completing pressure area risk assessments (Anderson tool). Of these notes, we did not observe anyone who required immediate escalation to a more in-depth risk assessment (Waterlow pressure area risk assessment) or patients who required a more in-depth risk assessment due to being in the department for four or more hours. As part of the safety and quality dashboard (SQD) staff monitored compliance with completing pressure area risk assessments within 24 hours of admission. Information showed from November 2016 to October 2017, 72.5% of patients received a pressure area care risk assessment within 24 hours of admission.

Within the patient records, there was a section for staff to record intention rounding. All 24 sets of records had evidence of hourly intentional rounding being conducted. As well as addressing any positioning requirements for those who needed help with repositioning, staff also recorded whether
the patient was in pain, most recent NEWS/PEWS score and whether nutrition and hydration was offered and accepted.

Mental health liaison team documented their reviews in the patient’s department records. This ensured staff had access to relevant information that informed their treatment plans. Within these documents, information about previous admissions was recorded as part of their relevant medical history. Staff also had access to patient-specific information, such as care programme approach (CPA) care plans, positive behaviour support plans, health passports and communication aids through the mental health liaison team.

**Medicines**

Medicines and medicines related stationery including prescription pads (FP10s) were managed appropriately. The ordering, storage and administration of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and the associated regulations. The department had suitable cupboards to store controlled drugs (CDs). We reviewed CDs in majors, resus and ambulatory care and found they were all in date and the balance matched the record books. The recording books had evidence of regular checks by staff in the department as well as periodic checks by staff from pharmacy.

Medicines which required storing in a refrigerator were done so appropriately and we saw evidence of regular checking of the refrigerator temperatures. Staff were aware of the actions to take if they found the refrigerator deviated from the normal range (2-8°C (Celsius)). However, we did not observe any thermometers which monitored the room temperature. We asked staff if there were any thermometers that usually monitored the room temperature but they were unsure. The recommended room temperature for storing medicines was below 25°C, the room at the time of our inspection was not extremely hot or cold; however, staff had opened the door. Staff told us the room did get quite warm when the doors were closed.

Medicines used in emergency situations were stored on resuscitation trolleys which had tamper proof seals in place and checked by department staff.

Emergency department patient records had an area where medications and intravenous fluids were prescribed. We reviewed 24 patient records and found where medication had been prescribed (20), there was evidence of staff administering this and signing the document when given. In addition to these records, we also reviewed two medicine administration records for patients due to be admitted who had an extensive medication history and found medications had been given as prescribed. The department monitored their compliance with medication administration through their safety and quality dashboard (SQD). Information showed from November 2016 to October 2017 the department scored 100% compliance with administering medication that had been prescribed. In addition to medication administering, the SQD also monitored compliance against recording patient allergies. For the same period, the department scored 100% compliance for this standard. During our inspection, we found one record which did not have any details entered the space which asked about allergies.

The department had patient group directions (PGDs) in place to enable qualified nurses to administer medications in a timely manner. Patient group directions provide a legal framework to allow registered health professionals to supply and/or administer specified medicines, to a predefined group of patients without them having to see a doctor. Staff told us medications covered by PGDs included simple analgesia (pain relief) such as paracetamol and ibuprofen, a topical local anaesthetic commonly used to ‘numb’ and area on a child before performing cannulation and nitrous oxide. We observed staff in triage administering pain relief in line with a PGD to ensure timely management of the patient’s pain.
Staff used a proactive approach to the management of patients with alcohol and illicit drug addictions. Medications to assist with withdrawal symptoms and associated side effects were offered to patients who required them. During our inspection we saw staff members proactively managing a patient who was beginning to suffer withdrawal symptoms by requesting medical staff prescribe medication in a timely manner so they could administer this when or if the patient required this. We later saw the staff member asking the patient if they would like the medication prescribed when they noticed the patient displaying signs of withdrawal.

Following a serious incident in the department (poor management of diabetes) we saw training had taken place. Staff demonstrated a sound understanding of how to recognise and treat diabetic emergencies. During our inspection we saw a patient who presented with a diabetic emergency. We tracked this patients care and found staff had followed the appropriate policies and procedures, administered medicines in line with the policy and continued to monitor the patient.

Medical staff adhered to local antimicrobial policies when prescribing patients antibiotics. Staff reviewed the use of antimicrobials when appropriate and tried to use targeted antibiotics rather than broad spectrum antibiotics, and where possible switched to oral preparations as soon as they could rather than prolonged intravenous use. However, we were not aware of any lead clinician for antimicrobial stewardship in the department or any audits completed on antimicrobial stewardship. Information received from the trust following our inspection did not demonstrate any medicines audits or antimicrobial stewardship audits had taken place.

Incidents

Never Events

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

From January 2017 to December 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 32 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 16 (50% of total incidents)
- Treatment delay meeting SI criteria with eight (25% of total incidents)
- Slips/trips/falls meeting SI criteria with four (12.5% of total incidents)
Information split by site can be found below:

**Lincoln County Hospital**

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Total incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>8</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>6</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

*(Source: NHS Improvement - STEIS (01/12/2016 - 30/12/2017)*

Information from our internal computerised database showed between 26 September 2017 and 26 February 2018 there were a total of 512 incidents reported for the Emergency Department (trust wide). The majority of these were graded as no harm (393 incidents). Of the remaining 119 incidents, 77 were graded low harm, 30 were moderate harm, two were graded as abuse and 10 deaths were recorded. We requested the number of incidents reported by Lincoln ED between September 2017 and February 2018. The trust provided us with a list of incidents however we were unable to ascertain the severity of harm that they had been graded as.

The department had a backlog of 110 incidents which included 13 serious incidents. Senior staff told us some of these incidents dated back to 2014, although most of these were more current. The leads for the service had developed a recovery plan to work through these incidents and establish any learning points from them which could be shared amongst the staff. After the inspection, the leads of the service shared the recovery plan with the CQC to provide further assurance as well as a time line for when the situation would be resolved. Staff acknowledged timeliness of completing this work was affected by the limited number of clinicians who could be involved in the investigation process.

There was an incident reporting policy available for staff to refer to and all staff knew how to access this. All staff told us they knew how to complete incident reports using the trusts electronic system, with most informing us they have previously raised an incident before. However, staff acknowledged they did not report everything they should report as they found it difficult to get the...
time to report incidents with the current pressures experienced in the department. There were also mixed responses about whether they received feedback about the incidents they reported. Some staff told us they always received feedback, however others told us they had never received any feedback and this impacted on their decisions on whether they reported all incidents or not. All staff told us they would report incidents which they felt were serious in nature.

Staff could discuss serious incidents which had occurred within their own department and other departments across the trust which had led to further learning or changes to processes or procedures. These incidents would usually be discussed during handover, although staff had also received emails in the past to inform them of learning points from any serious incidents.

The duty of candour is a regulatory duty that relates to openness and transparency and requires Providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were familiar with duty of candour and the concepts of openness and transparency. Senior staff and clinicians demonstrated a more in-depth knowledge of the duty of candour and gave examples of serious incidents when they had implemented the duty of candour.

We requested copy of mortality and morbidity meetings for the emergency department but we did not receive these.

We saw evidence within the department of safety alerts being shared with staff when they were relevant for the areas they worked in. We observed posters displayed around the department reminding staff to only administer a nebuliser with air and not oxygen unless otherwise directed by medical staff due to the implications it can have on patients with chronic lung conditions.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported 0 new pressure ulcers, four falls with harm and 0 new catheter urinary tract infections from December 2016 to December 2017 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at United Lincolnshire Hospitals NHS Trust**

![Graph showing prevalence rate of pressure ulcers](Source: Safety thermometer - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

Policies, procedures and clinical guidelines were based on evidence-based best practice and relevant legislation and were accessible to all staff members. We saw that the department implemented relevant clinical guidelines from the National Institute for Health and Care Excellence (NICE) and other relevant professional bodies such as the Royal College of Emergency Medicine (RCEM).

Assessment and treatment for patients with sepsis was in line with the NICE guidance 51(NG 51): sepsis recognition, diagnosis and early management. Regular audits were completed to ensure all patients were receiving timely treatment which was in line with NG 51. During our previous inspection in 2016, we found the department did not have an effective pathway in place for identifying and treating patients with sepsis and we issued a requirement notice under the Health and Social Care Act (HSCA) Regulated Activities (2014). During our current inspection, we observed staff effectively screening patients for sepsis using an evidence-based tool and successfully treating patients.

Other care pathways were available for staff to follow in the department. These provided details of the care that was required in line with recognised guidance and provided a proforma to document the care staff had given. Examples of pathways available for staff to use were venous thromboembolism (VTE) pathways, fracture neck of femur pathways and asthma management pathways.

A range of evidence based risk assessments and tools were used within the department. These included the SBAR (situation, background, assessment and recognition) tool when communicating with other staff members about patient’s clinical condition, the Anderson pressure area risk assessment and a Glasgow-Blatchford Bleeding score (GBS) to risk assess patients for a potential upper gastrointestinal bleed.

The current department admission documentation did not prompt staff to consider a patient’s mental health, there were only physical health and safeguarding assessments contained within this. However, if staff were aware of patients attending the department with mental health concerns, there was a mental health risk assessment form which would be used, and would direct staff on what actions to take in response to the findings.

The department had an audit programme in place which included both local and national audits. There was participation in the Trauma Audit Research Network (TARN) audits and some of the RCEM however there was acknowledgement that there could be further participation in national audits to enable benchmarking to occur. Local audits which the department participated in included consent audits, record management audits and local pain audits.

Nutrition and hydration

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
We observed staff obtaining sandwiches for the department which could be given to patients who were present in the department for a prolonged period. We also observed staff asking patients and their relatives if they wanted any hot drinks whilst they were in the department. Staff conducted hourly intentional rounding in the department and reviewing a patient’s nutrition and hydration was included within this.

Staff told us they tried to ensure a decision was made regarding whether a patient was required to remain ‘nil by mouth’ as soon as possible to ensure patients were not unnecessarily starved. There were some clinical conditions which would delay a decision on whether a patient would be allowed food and drink due to requiring assessments and clinical investigations, staff told us the most common cases where patients would remain nil by mouth for an extended period were for patients with abdominal pain and patients admitted with a suspected stroke. In cases where an extended period of nil by mouth would be expected, staff would ensure the patient received fluids intravenously.

The department admission documentation did not have an assessment for nutritional status within this and staff did not use any additional assessment documentation to identify if there were any nutritional concerns. Staff indicated an assessment using a universal screening tool was usually conducted within the ward areas.

During our inspection we observed two patients who were receiving intravenous fluids and were having their fluid intake and output monitored. These two fluid balance charts were both completed, although due to time of admission, an accurate balance would not be achievable. However, we also observed one patient who should have had their fluid intake and output monitored due to their clinical condition, however this was not completed. This was escalated to the nurse in charge at the time of identification. A senior member of staff told us there were some challenges around the completion of fluid balance charts within the department and this was something they intended to focus on, especially for patients who have screened positive for sepsis and patients where strict fluid balance is required.

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.7 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts. However, it is noted that although there were 333 survey respondents at this trust only 49 participants responded to this specific question.

The trust scored 8.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
The department monitored their pain management performance on the safety and quality dashboard (SQD). For the period November 2016 to October 2017 the department completed a pain assessment and recorded a score on average 82.6% of the time (monthly performance varied from 0% to 100% compliance). A further standard that was monitored on the SQD was patients being offered or administered analgesia (pain relief) within 15 minutes. For the same period, patients were offered or given analgesia within 15 minutes on average 57.3% of the time (monthly performance varied from 0% to 100% compliance).

All patients had their pain levels assessed within 20 minutes of entering the department, which is what was recommended within the Management of Pain in Adults (RCEM guidance, 2014). This pain score was then entered on to the electronic system as well as documented in the patient record when completing an initial review. Adult and young people were asked to rate their pain using a numerical score, for young children staff used a visual assessment (Wong-Baker pain scale) to rate the pain they were experiencing.

There was a mixed response from patients when we asked about receiving pain relief. Some patients told us they received their pain relief in a timely manner after receiving initial assessment and treatment. The majority of patients who were asked about their pain relief experience told us they received pain relief, but there were long delays. On two occasions, our conversations with patients prompted staff in the department to administer pain relief to patients.

Pain levels were reassessed dependant on the patient’s clinical condition. We observed staff asking patients regularly during intentional rounding if they were experiencing any pain or discomfort. We also observed staff responding in a timely manner by administering analgesia (pain killers) if patients did complain of pain. Although we saw good examples of staff assessing and responding to pain, staff did not produce an individualised plan of care in relation to a patient experience which is what was recommended in the Core Standards for Pain Management Service in the UK (Faculty of Pain Medicine, 2015).

**Patient outcomes**

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

Comparing Lincoln County Hospital to other hospitals on the 2016/17 Moderate and Acute Severe Asthma Audit (Adult and Paediatrics), performance was better in two metrics. These were:

- Standard 2a: Vital signs should be measured and recorded on arrival at the ED. Hospital: 40.9%; UK: 26%
- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 52.3%; UK: 25%

The hospital’s performance was similar in five metrics (in this context, ‘similar’ means that the hospital's performance fell within the middle 50% of results). These were:

- Standard 1a: O2 should be given on arrival to maintain sats 94-98%. Hospital: 15.9%; UK: 19%
- Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy. Hospital: 85.1%; UK: 77%
- 5a: Within one hour of arrival (acute severe). Hospital: 29.0%; UK: 19%
- 5b: Within four hours (moderate). Hospital: 26.8%; UK: 28%
- Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines. Hospital: 53.7%; UK: 52%

Note: Standard 5: If not already given before arrival to the ED, steroids should be given as soon as
possible as follows:
- Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
- Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
- Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

The RCEM standard was met in none of the seven standards.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Comparing Lincoln County Hospital to other hospitals on the 2016/17 Consultant Sign-off Audit, performance was better in two metrics. These were:

- Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Hospital: 25.0%; UK: 12.2%.
- Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 33.3%; UK: 9.7%.

The hospital's performance was similar in two metrics (in this context, 'similar' means that the hospital’s performance fell within the middle 50% of results). This was:

- Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Trust: 12.5%; UK: 10.6%.
- Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age. Hospital: 13.3%; Trust: 8.3%.

The national standard was met in none of the relevant metrics.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Comparing Lincoln County Hospital to other trusts in the 2016/17 Severe Sepsis and Septic Shock Audit, performance was better in 0 metrics and worse in four metrics. These were:

- Standard 1: Respiratory rate, oxygen saturations(SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Hospital: 43.1%; UK: 69.1%.
- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 25.5%; UK: 64.6%.
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 0.0%; UK: 30.4%.
- Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 20.4%; UK: 44.9%.

The hospital's performance was similar in four metrics. In this context, 'similar' means that the trust's performance fell within the middle 50% of results. These were:

- Standard 4: Serum lactate measured within one hour of arrival. Hospital: 60.0%; UK: 60.0%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 36.2%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 38.0%; UK: 44.4%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 12.5%; UK: 18.4%.

The national standard was met in 0 of eight of the relevant metrics.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

The trust did not participate in the RCEM vital signs in children 2015/16 audit.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16

The trust did not participate in the RCEM procedural sedation in adults 2015/16 audit.

(Source: Royal College of Emergency Medicine)

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

The trust did not participate in the Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From November 2016 and October 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average. The trust’s performance remained similar across the time period ranging from 6.2% in November 2016 to 7.0% in August 2017.
Senior staff for the department told us they had participated in the most recent RCEM procedural sedation audit, however the results demonstrated they were non-compliant with the standards. The audit identified various shortfalls in regards to this and an action plan for driving improvements had been developed. One of the main challenges faced was the lack of substantive medical staff in the department and the cascade of the learning from this.

Senior staff were aware of the lack of additional participation with national audits and there was a desire to engage more with them; however, the lack of substantive staff impacted on the data collection. A senior member of the medical staff did however share with us local audit information on a quality improvement project they had implemented. Following a serious incident where an aortic dissection was not diagnosed, staff had implemented a tool to enable identification of other potential cases. Staff acknowledged this condition was relatively rare; however patient outcome is improved if diagnosed early. Following the first audit of this improvement project, the tool had helped clinicians to identify when further investigations was required in 23 patient presentations. Of these, five patients had a dissection diagnosed and a further nine patients had an abdominal aortic aneurism (a bulge or swelling of the main vessel that runs from the heart down through the chest and abdomen). Staff told us the results of this audit were surprising due to the relatively rareness of the condition this aimed to highlight, however this has indicated the tool is effective in raising the suspicion that a dissection could be the cause of the patients clinical condition. Because of the first audit, a plan had been developed to improve the use of this tool.

Following our inspection, we requested information on the departments audit programme and any reports from recently conducted audits. The information received showed the planned audits to be undertaken during this year. In total seven items were on the programme, three of which were national Royal College of Emergency Medicine (RCEM) and a national Trauma Audit Research Network (TARN) audit, the remaining three were around consent, record keeping and the management of pain. As all audits were either not started or in the data collection stages, there were no results, reports or action plans for these audits.

### Competent staff

#### Appraisal rates

The trust provided appraisal rates for staff who required an appraisal from April 2017 to October 2017. As most appraisals are carried out at the end of the financial year figures do not include all staff members. From April 2017 to October 263 urgent and emergency care staff were required to
complete an appraisal with 79.1% of these having received an appraisal. This was lower than the trust target of 85%.

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

At Lincoln County Hospital 102 urgent and emergency care staff were required to complete an appraisal with 74.5% of these having received an appraisal. This did not meet the trust target of 85%. 82.3% of qualified nursing and health visiting staff had completed an appraisal and only 33.3% of medical and dental staff had received an appraisal (one out of three eligible staff).

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

(Source: Routine Provider Information Request (RPIR) Appraisals)
Staff told us the appraisals were meaningful and were a good opportunity to identify potential training needs for the following year. Staff also had informal one to one meetings with their line managers. One staff member in particular had used the appraisal system to access further training opportunities which they were due to go on secondment to complete. If staff were identified to be displaying poor or variable performance, this would be addressed through the one to one and appraisal system. If further management was required, this was completed with support from human resources.

We spoke with staff members who were currently on a preceptorship pathway in the department. They told us they felt well supported by the clinical education team as well as the staff in the department, all told us they had a member of staff who was designated as their preceptor who they worked regularly with. They had competencies which had to be complete before they were able to work independently in some areas of the department (e.g. triage).

As well as the secondment opportunities, staff also had access to additional training to enhance their current roles. Staff told us about the opportunities to access bespoke diabetic ketoacidosis (DKA) training in response to a recent serious incident in the department. There was also opportunity to complete enhanced clinical competencies in recognising a deteriorating child. Although all staff acknowledged the pressures felt within the department, no staff member told us they found it difficult to access training.

Until recently, the department had their own clinical educator who was responsible for in house training and competency assessments. A new staff member had been identified to take on this important role in the department to ensure training continues. All staff we spoke with told us how important this role was for the department and how much they had individually got from the clinical educator in the department.

Medical staff told us they had good access to teaching within the department. Middle grade doctors had access to half a day’s training once per month which was targeted on governance outcomes. Senior staff told us this was open to locum doctors, however locum staff we spoke with were not aware of this, and told us they do their own learning. In addition to this training, each Wednesday and Friday, there was short educational sessions conducted within the department which aimed to get all members of the team involved. During our inspection, we observed one of these sessions being conducted and noted a range of staff members attending this.

During our inspection we observed good nursing interventions and staff demonstrated to us they had the skills, knowledge and experience to identify and manage issues arising from patients’ living with for example, mental health conditions, a learning disability, autism and dementia. Information provided by the trust after the inspection showed there was training available to enhance staff knowledge and skills in managing the care of patients with specific needs.

Volunteer staff were employed within the department, and trust wide. The recruitment for volunteers mirrored the requirements for all other hospital staff (application form, disclosure and baring system checks and two references). Once recruited, all volunteers completed the trust induction programme which included (but not limited to) fire safety, infection control, information governance and safeguarding.

**Multidisciplinary working**

During our inspection we observed examples of effective multidisciplinary team working and mainly positive feedback about relationships with different departments and staff groups. However, we were also informed of some challenges experienced within the department. Senior staff told us about the challenges they had faced in getting specialist teams to attend the department to review
patients when emergency physicians had identified which speciality they would need referral to. With the intervention of the senior executive team, this had started to improve and team working with the medical speciality had especially strengthened however there was still some way to go with other specialities.

On the first day of inspection, we observed a diabetes nurse specialist attending the department to review a patient they had identified on the patient admitting system used in the trust. Staff told us the diabetes nurse specialist team were proactive in their approach to reviewing patients and often visited the department to review patients, even if no formal request for their assistance had been submitted. They worked with the staff to devise an individualised plan of care for the patient, and in some cases they managed the patient’s care locally to avoid admittance into the hospital.

A new team of stroke nurse specialists had recently been implemented at the trust to improve patient outcomes for patients with a suspected or confirmed stroke. Staff from the department would pre-alert the team if a patient with a suspected stroke patient was being brought into the department. During our inspection we observed this process in place, and saw the stroke nurse specialist was in the department in a timely manner ready to work with the team and complete initial assessments of the patient.

All staff without exception told us there was a strong relationship with the paediatric services in the hospital. We observed consultants and paediatric registrars attending the department to review paediatric patients within a short time of referrals being made. Staff could not recall any occasions when paediatric support or reviews had not occurred. If for any reason paediatric staff were delayed coming to the department, staff told us they would contact the department to make sure there were no urgent concerns and kept them updated on when they expected to be available to attend the department in person.

There was a team of allied health professionals (AHPs) and nurses based within the department who provided an assertive in reach (AIR) service. The team ensured there was a safe and effective process in place when patients were discharged home by completing home assessments and arranging additional equipment for those who required it. The team also worked alongside other members of the larger multidisciplinary team to prevent unnecessary admissions.

There was a good working relationship between staff from the department and the mental health services which supported them. Staff told us both the liaison and crisis teams were quick to respond to requests for reviewing patients and had built up a good rapport with them as they were frequently in the department. There was also access to an external drug and alcohol service for patients requiring this specialist support. They were available between 9am to 5pm, Monday to Friday. Referrals made outside of these times would be responded to on the next working day.

**Seven-day services**

The emergency department at this location was available for all patients 24 hours a day, 365 days a year. Within the department, there were areas which had times where they were unavailable to patients. The minors’ department was open between 8am to midnight and the ambulatory care unit was open between 8am to 10pm, both areas opened for these time periods seven days a week.

Patients had timely access to diagnostics such as X-rays and computerised tomography (CT) scans and support services such as pathology and theatres were available 24 hours a day. There was a dedicated X-ray department attached to the emergency department who could also complete plain film x-rays in the department if a patient was too unstable to move. However, staff told us there was only access to magnetic resonance imaging (MRI) during the weekdays with
limited access on a Saturday if required. Staff did not feel this impacted on the care they provided to patients.

There was 24-hour access to consultant directed interventions including critical care, interventional radiology, interventional endoscopy and emergency general surgery. Staff were able to recall times when they had needed to access these services. For patients presenting with a gastrointestinal (G1) bleed there were services available at this location to effectively manage these patients 24 hours a day, seven days a week.

There were dedicated porters in the department which provided a service 24 hours a day. Staff commented on how important this service was as it improved patient flow through the department.

**Health promotion**

National priorities to improve the population’s health in regards to smoking cessation, obesity, drug and alcohol dependency, dementia and cancer were supported. Staff involved patients where appropriate in decisions about their own health and well-being. Staff told us they had access to a range of patient information leaflets which would promote a healthier population. However, we did not observe any of these leaflets in the main department and did not observe staff handing any leaflets out to patients with the main aim of promoting a healthier lifestyle.

Staff told us about a recent health promotion campaign to educate families about the dangers of ingesting liquid wash tablets which were commonly found in homes. They had seen an increase in paediatric patients attending the department due to these types of incidents and found a health promotional campaign could reduce the number of incidents in the future.

A range of specialist nurses were available internally and externally who would attend the department on referral to them. The specialist nurses as part of their role would focus on empowering patients to monitor their own health and well-being, to ultimately maximise their independence. During our inspection we observed the diabetic nurse specialist providing this support to patients.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from April 2017 to October 2017 Mental Capacity Act (MCA) level 2 training had been completed by 80.4% of staff within urgent and emergency care. This was lower than the trust target of 90%.

Completion of MCA level 2 training split by staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Mental Capacity Act (MCA) level 2 training completed, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>80.5</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>68.0</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>41.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>73.7</strong></td>
</tr>
</tbody>
</table>

At Lincoln County, training for MCA level 2 training was below the trust target of 90% for all staff groups.

Deprivation of Liberty training information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Trust Provider Information Request Training)

The Mental Capacity Act (MCA) (2005) is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Despite none of the core groups of staff achieving the target for Mental Capacity Act (2005) training, we found staff had awareness of mental capacity and the Act. Staff told us there were policies and assessment documentation located on the intranet for them to refer to if they had a patient who did not have capacity to make decisions for themselves. In addition to this, there were care plans available for staff who were providing care and treatment to patients who lacked capacity. During our inspection we observed staff carrying out mental capacity assessments in a timely manner.

A consent policy was in place which was available to all staff and intended to guide staff to obtaining informed consent from patients. During our inspection, we did not observe any patients being formally consented for any care and treatment, however we observed all staff gaining verbal consent from patients before proceeding with any intervention, for example blood pressures or administering intravenous medication.

Staff demonstrated a sound knowledge of the Gillick competency and were able to competently discuss when they would use Gillick competency to assess the competency of a young person and whether they demonstrated the maturity to make decisions about their care and treatment, and whether they understood the implications relating to the decisions made. Staff were also aware of Fraser guidelines; however, told us they did not dispense oral contraception to patients and therefore were unlikely to use this. Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. Since this case, they have been used...
more widely for assessing the competency for young people to make decisions about their care and treatment.

At the time of our inspection, there were no patients detained under the Mental Health Act. Staff were generally aware of their responsibilities in relation to patients who may be detained, however they would seek further specialist input from the mental health liaison and crisis teams if required.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The trust's A&E Friends and Family Test performance (% recommended) was generally worse than the England average from November 2016 to October 2017. The graph is below:

**A&E Friends and Family Test Performance - United Lincolnshire Hospitals NHS Trust**

The trust's performance ranged from 79.8% in July 2017 to 86.9% in September 2017. This compares to the England range of 86.0% and 88.0%.

The percentage of patients who recommended Lincoln County Hospital was between 73.3% and 80.7%. There has been a small improvement in the recommend rate over the time period. The response rate for this hospital was between 16.5% and 18.7% each month. The graph below shows the FFT results for Lincoln County Hospital:
Evidence appendix United Lincolnshire Hospitals NHS Trust

Friends and family test (FFT) results for the period of November 2017 until January 2018 (the most recent published results at the time of our inspection) showed similar results from the previous 12 months. November 2017 saw a peak with recommendation at 81%, with slight declines in December 2017 (76%) and January 2018 (79%). The FFT is a single question survey which asks patients whether they would recommend the NHS service to their friends and family. The response rate for FFT remained stable during this three-month period, between 16.4 to 17.4%.

We spoke with 18 patients (14 adult patients and four paediatric patients) and eight relatives. Most of the feedback we received from patients was positive, with comments about how lovely and caring the staff were, the hospital was marvellous compared to others in the area and they had a positive experience in the department.

Despite this positive feedback, without exception all patients commented on how busy the department was and how long they had waited in the department. During our inspection, we observed the department experiencing an increase in activity, however all observations between patients and staff did not reflect this. Staff were still taking the time to ensure patients were comfortable.

Throughout our inspection we observed positive interactions between staff and patients. Patients were treated with compassion, dignity and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. We observed staff respecting the privacy and confidentiality of patients at all times, especially when undertaking any interventions. We observed staff closing curtains prior to completing procedures. The department included patient dignity on their safety and quality dashboard (SQD). One element they monitored themselves against was to ensure curtains were always closed when patient care and treatment was in progress. During the period November 2016 to October 2017 the department scored 100% for each month. In addition, other areas included on the SQD for patient dignity included the call bell being within reach of the patient at all times, patient modesty being maintained, patients reporting good communication from staff and staff introducing themselves. All elements scored 100% compliance during the period of November 2016 to October 2017. Our observations during our inspection supported the departments own findings. We saw staff always introducing themselves to patients and relatives when taking over their care and staff made sure patients could reach their bells when leaving their bedside.
During our inspection, we observed staff providing care and treatment to patients admitted with mental health concerns. Staff displayed very compassionate and non-judgemental attitudes towards these patients, and gave the same level of concern and respect as any other patient admitted into the department. In another observation, we observed a paediatric patient who was extremely distressed during their visit to the department. Staff displayed very calming and caring natures and attempted to provide comfort to the child whilst being treated. When the child was still upset, staff reassessed the situation to see if a different approach could be taken which was not as upsetting and distressing for the child.

**Emotional support**

We observed staff providing emotional support to both patients and relatives in an appropriate and timely manner. Staff considered patients emotional well-being as part of their intentional hourly rounding.

Despite the busy environment of the department, staff were aware of the benefit of having family or friends with a patient and the emotional support they can provide and encouraged them to remain with patients where appropriate. In the ‘fit to sit’ area, the number of family or friends was restricted due to space, however at times of reduce use of this cubicle, this was relaxed.

The service had clinical nurse specialists available to provide patients with additional support and advice if required. The department regularly requested the support of stroke, cardiac and palliative nurse specialists. We saw these specialists providing emotional support to patients during our inspection for example the stroke nurses.

The hospital had a bereavement service which staff from the department could access if additional support to relatives was required. In addition to the bereavement service, staff could contact the chaplaincy department to provide support to patients and their relatives if required.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored “about the same” as other trusts in 23 out of 24 relevant to caring. The trust scored “worse than” other trusts for one question which was “If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?”

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the</td>
<td>8.5</td>
<td>About the</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>doctors and nurses examining and treating you?</td>
<td></td>
<td>same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
### Understanding and involvement of patients and those close to them

We spoke with 18 patients during our inspection, the majority of patients felt they had received enough information about their care and treatment and any further care required, and had also been involved in decision making (where appropriate) about their treatment choices. We observed a consultant discussing with the parent of a paediatric patient potential discharge plans for the child. The parent was clearly concerned about taking the child home, however after thorough discussion with the consultant, agreed a plan which they had both come up with. The parent in this instance was made to feel like an important partner in their child’s care.

However, three patients told us they were not really sure what was going to happen next, with one patient saying, “they thought they might be waiting to go to a ward”. Another patient although was happy with the care and treatment received, as well as the information they had receive, their relative accompanying them told us the patient was concerned not all information was back yet and a full diagnosis not given, but acknowledged this was because they needed to return at a later date for follow up investigations. Both the patient and relative told us this would be on their mind until the follow up tests were completed.

Patients told us they felt comfortable in asking staff to explain things again if they had not understood what they had been told the first time round.

We observed staff communicating with patients in a way which they understood and using language they understood. For example, we observed staff talking with paediatric patients in a way which they made sure they could understand what was going on and what investigations and treatments they would need. In addition to this, we observed staff using pictorial charts to engage patients in their care.

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**Table:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
with paediatric patients when attempting to find out specific information about the pain they were experiencing.

Is the service responsive?

Service delivery to meet the needs of local people

The systems we identified on the previous inspection to meet the needs of the population were still in place and were now embedded practice. The rapid assessment and treatment area (RAT) had improved how the department coped with the pressures of high activity as well as the cubicle in the yellow majors’ area being turned into a ‘fit to sit’ area for patients who did not require a trolley. However, many staff members believed the size of the department was now becoming too small to meet the demand for the services. Senior staff told us there were plans to extend the resuscitation area, but no current time frame could be given as to when this would be completed.

Since our last inspection, a local community NHS trust had established a primary healthcare service within the department. The streaming nurse could direct patients through this pathway if they met the criteria.

There was a service level agreement in place with the local NHS ambulance trust for them to continue providing care and treatment to patients until they had handed over the patient to staff in the department.

The patient waiting area was spacious enough and had enough seating to accommodate the current flow of patients, however there were plans in place to rearrange the area and modernise the facilities for the patients. Currently, the rows of seating were close to the main reception window where the receptionist and streaming nurse were located. The reception area had a glass partition in place and a speaker system to aid communication. Staff were aware if patients were sat of the first few rows of seats, it was possible for them to over hear the patient at the reception desk, therefore breaching confidentiality. There were options available for patients to speak with either the receptionist and/or the streaming nurse in private, however at times of peak activity; this could be difficult to manage. The modification plans would alleviate the current concerns over the confidentiality issue as well as giving the reception staff and streaming nurse better visibility of all patients sat waiting to be seen.

A quiet area was available in the department (behind the reception desk) where patients could wait if they found busy environments distressing. However, this was also used as a relative’s room and, at times, an additional assessment room for patients admitted with a mental health illness.

The department had identified a room for patients requiring a mental health assessment. Although the room did not currently meet required standards, plans were in place to develop this room to meet the standards.

The department did not currently meet all the standards of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (2012). There was an area in the waiting room designated for paediatric patients to wait which had a door to this (providing an audio and visual barrier) however paediatric patients still had to enter through the same entrance as adult patients and then walk past them to get to the designated paediatric waiting room. This area could also not be monitored by the streaming nurse, instead there were sign advising the parents of the paediatric patients to alert staff if they felt the patient was deteriorating. The department had also attempted to designate a cubicle in majors and a bay in the resus area for paediatric patients, which had minimal decoration to identify this as a paediatric area, however
during our inspection, paediatric patients present in the department were not always placed in these areas.

**Meeting people’s individual needs**

**Emergency Department Survey 2016**

The trust scored “about the same” as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

The department had access to a range of translation and interpreting services. Staff were aware of a telephone service which could be provided and had information directing them on how to access this. Staff could also request face-to-face translation for patients if this was required. However, staff were unaware if they were able to access translation services for British Sign Language (BSL).

There were plans in place for how the trust as a whole would comply with accessible information standards, however at the time of our inspection; the department were still not fully compliant. There was no hearing loop system available within the department. This was previously identified on the inspection in 2016. A hearing loop system is a sound system that boosts the signal in a person’s hearing aid, therefore helping someone with a hearing impairment to focus on the sounds which are most important, for example, staff from the department talking to them. Staff also told us there was no way of identifying and flagging patients who required additional support in relation to their information and communication needs.

There was a referral system in place for patients with autism and a learning disability who required additional support. Information provided by the trust indicated an improved pathway for patients with autism or a learning disability, and measures were in place to increase staff knowledge and awareness through the implementation of local training and resource files.

Chaplaincy services were available at this location between 9am and 5pm, Monday to Friday and 9am to 5pm on Sunday too. Outside of these hours, the chaplaincy service provided an on-call service, however this also covered the other locations belonging to this trust. The hospital chapel/faith rooms were available to patients and staff at all times. The core team of chaplains were of Church of England and Roman Catholic denominations; however, all religious needs could be met if requested.

Staff told us there were resources available to meet the individual needs of patients living with dementia which included ‘twiddlemuffs’ and copies of the Abbey pain scale (an adapted pain scale for patients who cannot verbalise due to cognitive impairments of conditions such as dementia). There were no other resources or adaptations in the environment to meet the individual needs of a patient living with dementia.
For vulnerable patients, or patients deemed high risk of falls, staff told us they would locate them in a cubicle as near to the nurse’s station as possible and provide one to one care for them. During our inspection, we observed staff caring for a patient who appeared confused, however due to the pressures of the department, the patient did not always have a staff member providing one to one care for them.

Volunteer staff were available in the department to assist patients and relatives with their needs. During an evening visit to the department, we observed a volunteer member of staff sitting with a patient and chatting to them, as well as offering to make drinks for patients.

**Access and flow**

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for any of the 12-month period from November 2016 to October 2017.

Performance against this standard showed a trend of slight improvement with the median wait time ranging from 67 minutes to 79 minutes over the time period.

**Ambulance – Time to treatment from November 2016 to October 2017 at United Lincolnshire Hospitals NHS Trust**

![Graph showing ambulance time to treatment from November 2016 to October 2017](source: NHS Digital - A&E quality indicators)

We requested an update from the trust on the current data for the ambulance time to treatment time for the department. Information received on 21 March 2018 showed the mean time was 88 minutes, with a median time of 72 minutes. This meant the trust was still failing to meet the standard.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust breached the standard every month from December 2016 to November 2017. At the national level it was also seen that the standard was not met in any of the 12 months reported. However, the trust’s performance was worse than the England average in all 12 months.

The trust’s performance against this metric remained similar between December 2016 and November 2017.
We requested an update from the trust on the current data for their performance against the four hour target. Information received on 21 March 2018 showed the department on average met this standard for 72.3% of their patients.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted**

From December 2016 to November 2017 United Lincolnshire Hospitals NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average for the first six months. However, performance deteriorated month on month from May 2017 (8.3%) to November 2017 (22.7%) with the trust’s performance being worse than the England average from June 2017 onwards.
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from December 2016 and November 2017, one patient waited more than 12 hours from the decision to admit until being admitted.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients over four hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-16</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>Jan-17</td>
<td>104</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>81</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>44</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>286</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>446</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>491</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>547</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>730</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>806</td>
<td>1</td>
</tr>
<tr>
<td>Nov-17</td>
<td>814</td>
<td>0</td>
</tr>
</tbody>
</table>

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

Additional information was requested following our inspection to identify if there were any additional access and flow concerns. Information we received from the trust showed:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients over four hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-17</td>
<td>558</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>900</td>
<td>1</td>
</tr>
<tr>
<td>Feb-18</td>
<td>648</td>
<td>1</td>
</tr>
</tbody>
</table>

Information we received showed January 2018 had the highest numbers of patients waiting over four hours to be admitted after the decision was made to admit them. Staff told us the week preceding our visit to the department had also been extremely busy with many patients breaching the four hour target. This was a similar picture to many NHS trusts during this period.

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

From November 2016 to October 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average. The percentage of patients leaving before being seen ranged from 2.6% (April 2017 and October 2017) to 4.0% (August 2017). The England average ranged from 2.7% to 3.4%.
Additional information was requested following our inspection to identify what the percentage of patients was currently for leaving the department without being seen. Information showed there had been an increase in December 2017 to 4.8%; however, the information showed this was now reducing with January 2018 decreasing to 3.6% and February decreasing even further to 3.3%.

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

From November 2016 to October 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Performance against this metric has remained similar over time with the median total time in A&E ranging from 167 minutes (April 2017) to 185 minutes (December 2016). The England median total time in A&E ranged from 144 minutes to 154 minutes. We requested further information following this inspection to identify what the current median time was for patients attending this department. Information receive 21 March 2018 showed the median time had increased from 154 minutes, to 177 minutes.

**Median total time in A&E per patient - United Lincolnshire Hospitals NHS Trust**
Operational pressures in the ED for example, increases in demand, were communicated using the Operational Pressures Escalation Levels (OPEL) framework. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels ran from OPEL one; The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources to, OPEL four; Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised if the OPEL level runs at a higher state for long periods of time. At the beginning of our inspection (13 March 2018), the OPEL level was four. This did reduce to OPEL three at approximately 3pm the same day, however there remained significant difficulties and pressures within the department due to the lack of flow throughout the hospital.

Bed meetings were held at the trust three times a day (8.30am, 12.30pm and 3.30pm). At times of increased pressure on the hospital, additional meetings were held to try and identify additional capacity for the hospital which would therefore benefit the emergency department as this would increase the flow through the department. We accompanied the department matron to an additional bed meeting on the first day of inspection. We saw measures put in place at this meeting to try and create capacity within the hospital which included cancelling non-urgent admissions for operations.

Staff were aware of the escalation policy for the department and could confidently describe the additional measures they would put in place if demand on the service continued. This included increasing the RAT (rapid assessment and treatment) area to a four-bedded bay instead of three and to convert a cubicle in the green area of majors to a ‘fit to sit’ cubicle which could accommodate four patients.

During the previous inspection, the ambulatory care unit was located in the department which meant a good use of this area. When we returned on this inspection, the ambulatory care unit had moved away from the department. On the second day of our inspection we found despite the number of patients attending the department increasing, this unit was underutilised. We raised this with senior leaders who acknowledged since the unit had moved, there was less in-reach from the ambulatory care unit and were currently reviewing how to effectively use this area so that access and flow in the department could be improved.

A three bedded, consultant led RAT area was available in the department to provide early assessment of ‘majors’ patients arriving by ambulance. At the time of our inspection, we saw the RAT area was effective at reducing the time taken for ambulance crews to handover. However, staff told us the time taken for crews to handover can range from 20 minutes to above four hours, with noticeable delays starting in August 2017. One staff member said they had known delays of over six hours quite recently due to an increase in pressures on the department.

There was a designated flow coordinator for the department between 10 am to 10pm. Their sole purpose was to ensure there was good flow through the department and to escalate patients who were waiting for investigations. They were responsible for ensuring the department risk assessment was updated regularly so the trust had accurate oversight of the risks in the department.

Staff told us they tried to ensure paediatric patients were quickly seen and did not spend long in the department. They continued they ideally tried to see them within an hour and decide the future plan in this time (admit to paediatric ward or discharge home), however at the time of our inspection, they had not conducted any audits to demonstrate this.
Learning from complaints and concerns

Summary of complaints

From October 2016 to September 2017 there were 152 complaints about urgent and emergency care services. The trust took an average of 73 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 152 complaints, 117 had been closed at the time the data was provided and only 7.7% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days. Even when taking this target into consideration still only 21.4% of all of the closed complaints were closed within 50 days.

At Lincoln County Hospital there were 68 complaints. The trust took an average of 69 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 68 complaints, 57 had been closed at the time the data was provided and only 10.5% of these had been closed within 35 days. The trust has a further target to close 80% complex complaints within 50 days. Even when taking this target into consideration still only 28.1% of all of the closed complaints were closed within 50 days.

There were 12 complaints that were re-opened in the time period.

The most common themes complained about at Lincoln County Hospital were delay or failure to diagnose (nine), delays in treatment (eight) and wait times in the department (seven). These two themes reflect the most commonly reported serious incident types for urgent and emergency care at this hospital (diagnostic incident including delay meeting SI criteria and treatment delay meeting SI criteria). There were nine complaints regarding communication which were split as follows: communication with patients (four), communication with relatives/carers (four), patient not listened to (one). There were also six complaints relating to the attitude of staff (three regarding medical staff, two related to nursing staff and one related to administrative staff).

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

At the time of our inspection, we were told there were three complaints currently open which had been responded to by senior staff from the department within the expected time frame. The senior staff told us one of the complaints was now going to be taken to the next level in the complaints process as the complainant was unhappy with the response. The main themes which senior staff had identified from the complaints was in keeping with the themes above, with long waits for treatment being the most common complaint they had dealt with.

The trust had an up-to-date complaints policy. The policy was available for staff to access on the staff intranet. The policy and procedure provided guidance and standards for the handling of complaints. Staff would try to handle any complaints locally, however if these could not be resolved, patients and their relatives would be directed to the patient advice and liaison service (PALS). During our inspection, we observed signs around the department providing advice on how to complain, however there were no patient information leaflets for patients or their relatives to take away.

During our inspection, most patients and their relatives were complimentary about the care and treatment received, however we did receive a complaint from the member of the public which we escalated to the nurse in charge and matron at the time. As they requested to make the complaint a formal complaint, we provided the patient with the details to enable them to do this.

Not all staff were able to give examples of any formal complaints which had been made against the department or provide examples of how complaints had changed practice within the
department. However, senior staff told us intentional hourly rounding had been implemented in the department following a formal complaint.

Is the service well-led?

Leadership

The emergency department was part of the integrated medicine business unit at this location. Overall leadership for the department came from the head of service, head of nursing, matron and ward manager, at the time of our inspection there was no clinical director. The department also had a business manager and dedicated operational service manager.

Leaders demonstrated they had the experience, knowledge and skills to lead the service. Despite the pressures the department currently faced, providing a service which focused on the safe care and treatment of patients was their priority. It was however clear that not all leaders had the capacity to lead in a way they choose. This was evident in the limited amount of time for quality improvement and the management of the incident (including) serious incident backlog.

Senior staff told us they were not aware of any staff members leading on mental health. However, they felt this did not hinder them as they had a good relationship with the local community trust who provided mental health care.

Not all senior staff were aware of the Royal College for Emergency Medicine (RCEM) guidelines and associated audits. RCEM guidelines are considered as fundamental guidelines for professionals working in emergency medicine. Participation in RCEM audits enables national monitoring of standards of care and adherence to evidence based guidance. The audits that the department had participated in, leaders had not delivered feedback to the rest of the team.

Staff told us most of the local leadership team were visible and supportive. There was high praise for the ward manager and matron of the department, and there was an awareness of the head of service. However, staff told us they rarely saw the head of nursing in the department.

Staff were aware of the executive members of the trust and told us they would regularly visit the department. Staff were especially aware of the Chief Operating Officer as they had been extremely helpful in developing relationships with other specialities in the hospital and problem-solving delays in reviewing patients.

Vision and strategy

The trust vision; working together to provide sustainable high-quality patient-centred care for the people of Lincolnshire was underpinned by five values; patient centred, safety, excellence, compassion and respect.

The vision and values had been included as part of an extended communications campaign that included engagement events, new contemporary visible brand identification for the trust and live social media events with staff.

To ensure all staff adhered to the vision and values of the trust, a new staff charter and personal responsibility framework had been developed. The charter was a two-way process of identifying what the trust expected from staff and what the staff should expect from the executive team to enable them to drive forward the vision of becoming a trust who provided excellence in rural healthcare.

At the time of our inspection, staff were aware and able to recite the values of the trust, however they were unaware of any of the further developments to embed these values.

The trust had developed their ‘2021 Strategy’ which focused on two aspects, striving for excellence and delivering excellence and was underpinned by the values and vision of the trust.
Despite the emergency departments within the trust featuring as a key objective within this strategy and more specifically the Lincolnshire sustainability and transformation plan (STP) staff we spoke with were not aware of the strategy and how this impacted them directly. They had personally not been involved with any consultation activity.

Staff told us senior staff were currently working on a set of local values and a vision for the department. There had been local engagement with staff to identify what they wanted from a team and what they as a team wanted the service they provided to look like.

Culture

During our previous inspection, morale of all staff (nurses, doctors and extended members of the team) was reported as low. During this inspection (March 2018) despite all staff telling us how difficult the department had been due to the increase in activity and pressures that come along with this, morale was high and we observed staff members smiling and engaging with each other during their shift. Staff without exception demonstrated a committed and passionate attitude about the work they do, with a focus on providing positive patient care and treatment.

Staff mainly felt respected by their peers and senior colleagues, however there were some staff (from a variety of roles) who felt there was a group of bands six junior sisters who were not as respectful to those below them as they should be, and at times made them feel that their voice was not as important as others. Staff did highlight though, this was a minority of junior sisters and was not a reflection of the majority of them. On the whole staff told us the team was a very strong and supportive team.

Local managers told us how proud they felt of the team in the department, especially as they acknowledged how much pressure the department had been put under. They were especially humbled by the attitude of staff members who have ‘got on with the job’ and rather than telling staff and the leadership team ‘they can’t do something’, they have always approached the situation with a ‘what can we do’ attitude.

All staff told us they felt very supported by their leaders and would feel comfortable going to them to raise concerns. Staff were encouraged to work in an environment of openness, honesty and transparency. Staff had a good understanding of the duty of candour and exercised the principle of this on all levels. There was a ‘Being Open and Duty of Candour’ policy available to staff, with a training module due to imminently be released to enhance staff knowledge.

Staff were aware of the whistleblowing policy and the appointment of a freedom to speak up guardian. The staff charter which had been released for staff to sign up to also identified the expected behaviours of staff, therefore supporting staff to raise concerns if they witnessed unacceptable behaviours in others. Trust level information showed there had been 15 whistleblowers between November 2016 to September 2017, with the main theme of the complaints being around bullying and harassment. During our inspection we were not made aware of any bullying or harassment in the department and all staff felt they were treated equally.

Staff were satisfied with the mechanisms currently in place for identifying developmental needs and the subsequent action taken to further develop staff. Appraisals were meaningful and staff were attending additional competency courses to further develop them.

Governance
The systems, structures and processes in place did not always operate effectively to support the delivery of the trust’s strategy and good quality, sustainable services. The department had embedded processes within the department to ensure patients were streamed and treated as quickly as possible. In times when pressures were to high activity, there were processes in place to ensure staff had oversight of patient’s clinical conditions and were safe from avoidable harm. However, over a period of four years, the department had allowed a backlog of incidents to build up and were now trying to manage this to reduce this backlog and where possible, ensure lessons were learnt from the incidents raised. Staff told us some of the incidents within this backlog were before their time, however they had devised a programme to address this issue.

There was a service level agreement in place with the local NHS ambulance trust to continue to provide monitoring to a patient until they were handed over to the department team. Staff from the department had been key to this SLA being put together to enable a safe environment for patients being brought into the department. Staff from both trusts told us they felt this process worked well.

All staff were aware of the roles and responsibilities they held. There was a clear pathway for escalation in the department when situations required escalation to a more senior member of staff. Day to day leadership on the ‘shop floor’ appeared effective and we observed effective communication between the nurse in charge and the emergency physician in charge (EPIC).

Senior staff told us there were regular governance meetings held which they attended. Any relevant information which needs to be cascaded out to the wider team happens through handover or they will write this in the communication book. There were plans for all band six nurses in the department to start their own governance meeting which will feed into the main monthly governance meeting; however, this was yet to begin. Staff on the shop floor felt they had relevant information cascaded down to them from meetings; however, there was room for improvement. They did not have regular staff meetings where general information about governance issues could be discussed.

The senior leadership team were responsible for overseeing the management of sepsis and ensuring staff had completed training. They had an oversight of the monthly sepsis audits and were sighted on areas which required further training.

Management of risk, issues and performance

Overall, we found risks, issues and performance were managed. The leadership team had an oversight of the risks to the department and these were escalated to the trust risk register. Information about the department’s performance was generally updated as required, with very few gaps identified on the safety and quality dashboard (SQD). Management of current incidents and complaints was generally managed well and the department, although had levels of high activity and additional pressure, was managed well. However, there were concerns about the large number of historic incidents which had not been addressed as well as staff not routinely reporting all incidents, only those of high significance. A fairly robust recovery plan had been created for the management of the historical incidents backlog, however due to low numbers of clinical staff who were competent to investigate these, the timescale for these to be addressed was concerning. A deadline for the more serious incidents to be dealt with had been set, however we were less assured that the remaining backlog would be addressed with equal speediness. As a result of infrequently receiving feedback from incidents they had previously raised, or only receiving information about high level incidents, staff told us they routinely did not raise incident reports for the lesser serious incidents, despite being aware learning from these incidents could be identified which could prevent a serious incident in the future. We were therefore not assured that the
leadership team always had robust control, management and oversight of the risks in the department.

There was a process in place to identify record and manage risks. The leadership team all provided their top concerns or risks that they perceived for the department. Concerns included recruitment and retention, crowding in the department, ambulance handover and the environment, especially in regards to paediatric patients. We reviewed the department risk register which showed five risks. Of these risks, the top three (staffing and dependency on agency and locums, environment (especially for paediatric patients) and crowding and long waits) were escalated to the trust level risk register. We saw evidence of regular review of each item and updates on any mitigated actions taken. However, we did not see any risks on the risk register in reference to the historical incidents backlog. Staff on the shop floor were aware of some of the risks which were identified, the most common examples given were the staffing (especially retention of staff who have both adult and paediatric qualifications) of the department and the environment no longer being fit for purpose. However, staff told us they had never had sight of the department risk register and this was not an area which was discussed routinely.

Audit participation was low in some areas. For example, the department had not participated in a number of RCEM audits including for example; ‘vital signs in children’, ‘procedural sedation in adults’ and ‘venous thromboembolism (VTE) risk in lower limb immobilisation in plaster cast’. There was also little evidence of any other local audits which would impact on improving performance; an example of this was prescribing audits within the department. Senior leaders told us this was partially because of the low numbers of substantively employed medical staff within the department. When audits were conducted in the department, there was not always evidence of action plans being developed to identify where work was going to be focused to improve the outcomes. An example of this was identified in the cleaning audits where only five months out of the 12 had an action plan completed for addressing any shortfalls.

Following an unfortunate incident where an aortic dissection was missed and a fatal outcome being observed, clinical staff from the department had led on a risk management project which attempted to learn from this and prevent further errors being made in the future. The first audit of this was completed recently and results of this exceeded the expectations of those involved with further dissections being diagnosed as well as nine patients being diagnosed with an abdominal aortic aneurism. Although the results were positive, areas of further improvement were identified and the next phase of this project will not concentrate on implementing these improvements.

On the previous inspection, we identified there were concerns with the department’s ability to respond to a major incident and in particular if the major incident had a chemical, biological, radiological and nuclear (CBRN) element to this. During this inspection, we saw significant work had been done to update the equipment and how this is stored. There had been additional storage built for large items of equipment, which had subsequently ‘decluttered’ the original room where equipment was kept. Items were stored in trolleys which were sealed but had visible expiry dates displayed on them and updated action cards present. Staff told us they had recently conducted an exercise (exercise glitter) to practice their response to a chemical attack. This was successful and staff had gained a lot from this exercise.

Staff were aware the room that was identified as the ‘place of safety room’ did not currently adhere to the required standards, however there were no other concerns shared with us about the provision of services for mental health. Staff were knowledgeable of the pathways in place, and were positive about the response from the mental health teams when they contacted them. We observed significant actions had been taken following our last inspection to ensure the department was more prepared for mental health patients and information received from the trust, following this inspection, showed where further actions were planned.
**Information management**

Staff had access to information they needed to carry out their roles effectively with policies and procedures available on the trust’s intranet. There were also resources to enhance the care being delivered to some patient groups available on the intranet, for example flow charts and checklists for providing care and treatment to mental health patients.

Patient identifiable information was managed appropriately. During our inspection we did not see any occasion when patient records with confidential information were left unattended, despite them not being stored in a lockable trolley. Notes from patients who had been discharged were dealt with appropriately and returned to a secure location for filing.

The trust collected and managed information appropriately. Staff had access to information on patients’ care and treatment when they needed it, and there were no occasions when they failed to access important information about a patient. There was an electronic system in place which had alerts about any specific requirements for a patient, for example paediatric patients known to the local authorities.

Systems and processes were in place to ensure data and notifications were submitted to external bodies as required, for example serious incidents to both the Care Quality Commission and the commissioners of the service.

Staff were required to report (using the internal reporting system) when a patient had undergone detention in the department. A multi-agency case review system had been developed and introduced to enable a reflective learning process to be undertaken following detention of a patient. To ensure adherence to policy and procedures occurred, these were then presented to the Mental Health & Learning Disability Strategy Group for review.

**Engagement**

There was an awards process in place in the department (golden stethoscope and golden thermometer awards). These were a monthly awards process and recognised staff who had gone above and beyond in their role.

After the previous inspection, the department experienced a high turnover of staff. The local leadership team worked hard to engage all staff members, and re-establish a team ethos within the department. A compliments jar was started for staff to put entries into and the head of service devised a board which displayed all entries. Each entry had a response to ensure staff felt their input was worthwhile.

Staff from the department used social media as a way of engaging with each other. This was open to all members of staff in the department, regardless of role and was used appropriately. Most recently staff told us about posts they had done recently which everyone was involved in. One member posted something positive about the department and one idea for improvement, following this they would then request another member of staff to do the same. Staff told us it demonstrated how dedicated everyone was to the department, but also there were some good ideas suggested for improvements to the department.

The department tried to engage the public with their views in the department. We observed a ‘you said, we did’ board within the department which was displayed in the waiting area. Examples of issues raised were patients felt there was a lack of communication and long waiting times. There were responses to both of these issues and we saw evidence of the department organising a system to be installed to update patients on specific information relevant to the department, including waiting times.
At the time of our inspection, we did not see any specific engagement arrangements in place to receive feedback with patients who had mental health and emotional well-being concerns or engagement with external organisations who provide support to people with mental health or emotional well-being concerns. There was also no specific engagement with staff about experiences of delivering or coordinating care for patients with physical and mental health needs.

**Learning, continuous improvement and innovation**

Staff from the department told us they were always striving to improve the quality of care and treatment they provide. Learning from previous serious incidents was important to all staff members for this journey of continuous improvement. One example where improvements were made which had a positive impact on patient care was intentional hourly rounding. Before this was introduced, there was an ‘ad hoc’ approach to reviewing basic activities such as positioning and pressure areas, nutrition and hydration and pain levels. The introduction of this intentional hourly rounding ensured all staff members were focused on ensuring patients were comfortable and well cared for and there was documented evidence of when staff reviewed a patient. From a patient perspective, this ensured they saw a member of staff regularly and provided comfort for them in what can be a busy environment.

The invention of the ‘Trueman Show’ risk assessment has demonstrated where learning from an unfortunate incident can be used positively. The risk assessment tool had been welcomed by all staff members in the department and initial results had shown an improvement in the diagnosis and onwards treatment of a life-threatening condition.

There were planned refurbishments due to take place in the department which would improve the quality of care provided to specific patient groups. The most imminent refurbishments planned were for the room identified as the place of safety met the Psychiatric Liaison Accreditation Network (PLAN) standards. Work had already started (appropriate emergency assistance alarms fitted, glass panel in the door), however at the time of our inspection, the department was waiting for the room to be completed. Additional plans were in place to improve the resus room, by increasing the number of bays located within this. There were no confirmed dates for when work would start on this, however all staff told us how this would be a positive improvement to the department.
Medical care (including older people’s care)

Facts and data about this service

The Medical Care Service at the trust provides care and treatment for Acute Medicine, Elderly Medicine, Frailty, Respiratory Medicine, Gastroenterology, Diabetes & Endocrinology, Stroke Medicine, Cardiology, Nephrology, Neurology, Clinical Haematology, Oncology, Radiotherapy, and Specialist Palliative Care.

There are 495 medical inpatient beds located across 24 wards.

Lincoln County Hospital

<table>
<thead>
<tr>
<th>Location site name (CQC registered location)</th>
<th>Team/ward/satellite name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>Ashby Ward</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Burton Ward</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Cardiac Short Stay Ward / 2 Cath Labs</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Carlton-Coleby Ward</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Scampton Ward</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Dixon Ward</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Johnson/Coronary Care Unit</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Lancaster Ward</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Navenby Ward</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Stroke Unit</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Waddington Unit</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>Medical Day Unit</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>FAU</td>
</tr>
</tbody>
</table>

A site breakdown can be found below:

- Lincoln County Hospital: 260 beds are located within 12 wards

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

From October 2016 to September 2017 the trust had 70,960 medical admissions. Emergency admissions accounted for 31,481 (44%), 37,660 (53%) were day case, and the remaining 1,819 (3%) were elective.
Admissions for the top three medical specialties were:

- General medicine, 27,484
- Clinical oncology (previously radiotherapy), 8,005
- Gastroenterology, 7,941

(Source: CQC Insight)

Between October 2016 to September 2017 medical specialties at this site treated 44,035 patients, which represented 54% of all medical patients treated in the trust.

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of between 90 to 100% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical/dental and nursing staff in medicine is shown below:

Lincoln County Hospital – medical/dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>57</td>
<td>61</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>54</td>
<td>61</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>53</td>
<td>61</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>52</td>
<td>61</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>52</td>
<td>61</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>51</td>
<td>61</td>
<td>84%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>51</td>
<td>61</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>48</td>
<td>61</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>46</td>
<td>61</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>37</td>
<td>61</td>
<td>61%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>33</td>
<td>61</td>
<td>54%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>5</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

There were 13 training courses eligible for medical and dental staff of which the trust only met for the target for one module for equality, diversity and human rights. The trust did not meet the target for any other module, the lowest completion rate was 0% for medicine management training of which nine medical and dental staff were trained yet none were eligible for the module.
Last year the medical and dental staff for medicine did not meet the training completion rate, reaching 82% for the financial year April 2016 to March 2017.

Lincoln County Hospital - Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>340</td>
<td>350</td>
<td>97%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>328</td>
<td>350</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>323</td>
<td>350</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>316</td>
<td>350</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>316</td>
<td>350</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>313</td>
<td>350</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>303</td>
<td>350</td>
<td>87%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>275</td>
<td>350</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>268</td>
<td>350</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>255</td>
<td>350</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>224</td>
<td>350</td>
<td>64%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>166</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>27</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

There were 11 training courses eligible for qualified nursing staff of which the trust met for the target for three modules with the highest completion rate at 97% for equality, diversity and human rights.

Last year the qualified nursing staff for medicine met the 88% completion rate and is close to this completion rate for the date period April 2017 to October 2017 (84%).

- Lincoln County Hospital had an 89% mandatory training completion rate.

(Source: Routine Provider Information Request (RPIR) – Training)

Each ward monitored the completion of mandatory training by subject and reviewed this monthly. For example, the latest information for Waddington ward noted an overall 95% completion rate across all subjects, with a range from 68% for resuscitation to 96% for slips, trips and falls and equality and diversity.

At our last inspection we identified an urgent need to improve staff training compliance. This was a long-term challenge due to persistent short staffing on each ward. However, we found evidence in each clinical area that training compliance was improving and staff were given protected time to
complete this. Clinical nurse educators and matrons supported ward teams to access training despite increasing pressure on services.

Safeguarding

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical/dental and nursing staff in medicine is shown below:

Lincoln - medical/dental

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>53</td>
<td>61</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>53</td>
<td>61</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>49</td>
<td>61</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>49</td>
<td>61</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff were eligible to complete four of the possible six safeguarding training modules set out by the trust for medicine, they did not meet the 90% target for any of the modules.

Lincoln County Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>327</td>
<td>350</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>327</td>
<td>350</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>320</td>
<td>350</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>319</td>
<td>350</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

There were four safeguarding modules eligible for qualified nursing staff of which the trust target met for the target for two modules.

- Lincoln County Hospital met the 90% target and had a 92% safeguarding training completion rate.

(Source: Routine Provider Information Request (RPIR) Training)

A safeguarding lead was in post and worked with safeguarding link staff on each ward to provide care for vulnerable patients. A senior nurse on Burton ward told us safeguarding training had been significantly improved and all staff had been given protected time in their rota to ensure they completed it. Training for vulnerable patients living with dementia had also been increased and improved to include scenario-based training.
All of the staff we spoke with demonstrated a good standard of knowledge of safeguarding, including how to recognise signs of abuse and how to act on these. Staff were also knowledgeable on the action to take when they suspected or confirmed female genital mutilation (FGM) or when they had evidence of radicalisation in line with the government’s Prevent framework.

Cleanliness, infection control and hygiene

Between February 2017 and February 2018, the hospital reported one instance of methicillin-resistant Staphylococcus aureus (MRSA), four cases of methicillin-sensitive Staphylococcus aureus (MSSA) and 21 cases of Clostridium difficile (C.Difficile) acquired on site.

The trust participated in the national patient-led assessment of the care environment (PLACE), which assessed wards and clinical environments against six criteria. In 2017 medical inpatient wards scored 97% in the assessment for cleanliness, which represented an improvement from the 2016 score of 93%.

From looking at patient notes and observing nurse handovers we found staff correctly assessed identifiable infectious patients for care in a side room. However, on Lancaster ward we found three patients being treated in side rooms that displayed notices in relation to infection control. Each patient needed enteric isolation and the notices stated that doors must be kept closed at all times. Each door was propped open for the duration of our time on the ward. We asked a nurse about this who told us they were open because the patients felt isolated with the doors closed and nurses followed more stringent infection control practices as a result. There was no hand gel available at the entrance to one of the side rooms, which meant we were not assured anyone entering and leaving the room were able to sufficiently disinfect their hands.

During our observations of patient care staff demonstrated good adherence to hand hygiene practices, including washing their hands and using antibacterial hand gel at appropriate intervals. We also saw appropriate use of personal protective equipment (PPE) such as disposable gloves and eye goggles in the cardiac catheter laboratory.

Although all clinical areas we inspected were visibly clean, monthly audit data indicated a need for more consistent standards. For example, the latest ward cleanliness score for Carlton Coleby ward indicated 86% compliance, which did not meet the trust’s minimum standard.

Staff used bright green ‘I’m clean’ stickers to indicate when an item of equipment or furniture had been cleaned and decontaminated and was ready for use. We found appropriate segregation of such items between utility rooms.

We reviewed a sample of cleaning schedules and audits with the domestic services supervisor on Carlton Coleby ward. Housekeeping and domestic teams used cleaning schedules specific for each clinical and non-clinical area and checklists were in place to indicate when these had been completed. This included daily water flushing checks. We found the appropriate staff had fully completed each check list.

Although antibacterial hand gel was readily available throughout the hospital and clinical areas, its positioning at the entrance to most wards presented a risk of cross-contamination. This was because the hand gel was located on the exterior side of ward entry doors, which meant visitors then had to touch the door handle to gain entry to the ward. There was no hand gel immediately inside most ward doors, which meant hands could be contaminated on entry. This did not apply to the stroke unit, where hand gel was more appropriately located.

Staff in the endoscopy unit carried out water safety checks in line with national guidance and equipment manufacturer’s standards. We looked at records of these checks for the previous six months and found them to be fully completed.
Environment and equipment

We saw pressure mattresses and bariatric equipment in use around the hospital and staff told us these were readily available when needed. We looked at a sample of 19 items of equipment across medical wards and found they had undergone servicing in line with planned maintenance schedules.

In 2017 medical inpatient wards scored 95% in the PLACE assessment criteria for condition, maintenance and appearance, which was a significant improvement from the 84% score achieved in 2016.

Each ward or clinical area had a resuscitation trolley with a defibrillator and other emergency medical equipment. Clinical areas additionally had an anaphylaxis kit and an extravasation kit, used to contain a spillage of intravenous (IV) medicine. In all cases kits had tamper-proof seals with the last usage and check date documented. We checked each trolley and stock of equipment in every medical ward we visited; including daily signed checks to indicate staff had inspected equipment, medicines and disposables. We found staff had consistently documented these checks every day for the previous three months with no missing dates.

Safety equipment in the Ingham suite was appropriate for use in clinical areas that handled cytotoxic medicine. This included a cytotoxic drug spill kit and colour-coded cytotoxic sharps bins. In both cases items were labelled and dated appropriately.

We inspected all inpatient wards against the standards of the Department of Health (DH) Health Building Note (HBN) 00/09 in relation to infection control in the built environment and DH HBN 00/10 in relation to the condition of flooring. One side room on Carlton Coleby ward did not meet the standards of HBN 00/10 as some of the vinyl joints between the floor and wall had detached, which presented a risk bacteria could build up. The facilities manager was aware of this and plans were in place to repair the flooring. Some areas of flooring in patient bays in Lancaster ward were also damaged. Flooring in all other clinical areas complied with the DH standard.

Staff in all areas complied with DH Health Technical Memorandum (HTM) 07/01 in relation to the Safe Management and Disposal of Healthcare Waste (2013). This meant staff segregated waste by type using appropriate colour-coded bags and stored them in secure areas.

In most wards we found staff stored chemicals in adherence to the Control of Substances Hazardous to Health Regulations (COSHH 2002), including in safe and secure areas. However, on Lancaster ward we found five boxes of chlorine tablets were stored in an unlocked cupboard in an unsecured room with the door propped open. We also found chemicals readily accessible in an open cupboard on Dixon ward. We spoke with staff about both instances and they immediately secured the rooms.

Quarterly decontamination audits of endoscopic equipment took place in line with national standards and as required by Joint Advisory Group (JAG) accreditation guidelines. We reviewed the most recent two audits for 2017/18 and found an Authorising Engineer (Decontamination) had carried them out and found all practices to be satisfactory. They had also made appropriate recommendations to ensure audits were maintained.

Chemotherapy in the Ingham suite was provided through a combination of treatment rooms and treatment chairs. The suite also had a triage area and changing rooms shared with the radiotherapy service.

Burton and Scampton wards had been refurbished and bed bays had been fitted with sliding doors that were used to prevent the spread of infection when patients with such risks were admitted.
Assessing and responding to patient risk

During our inspection we reviewed a sample of 35 patient records across all wards. We found standards of risk assessments to be consistently good with fully completed and updated falls risk assessments, body mapping as part of the SSKIN bundle and nutrition and frailty risk assessments. On the stroke unit we found staff had clearly documented the use of all medical devices, including the tracing details for single-use items as well as clear treatment plans following ward rounds. Each record also included up to date risk assessments, patient demographic details and evidence of regular visual infusion phlebitis (VIP) scores. Records we reviewed on Ingham suite additionally included schedule and cycle information for chemotherapy.

The trust participated in a commissioning for quality and innovation framework (CQUIN) for sepsis screening as part of an action plan and programme to improve the monitoring of deteriorating patients. Beginning in July 2017 the trust reviewed 20 inpatients per month that received a positive sepsis result from a screen and identified their treatment against national sepsis standards. This meant the CQUIN identified whether patients received a screen within 60 minutes and whether they received antibiotics within 60 minutes. Between June 2017 and January 2018, the compliance rate with screening and treatment standards was 61%. This average was significantly below the trust’s target of 90% and reflected a range from 45% to 75%. The hospital did not meet the 90% standard in any month during this period. Performance was generally better in the measure of staff initiating antibiotics treatment within 60 minutes. For example, between October 2017 and January 2018, staff achieved this in 96% of cases. In the same period patients were screened for sepsis within 60 minutes in 64% of cases. This indicated staff were responsive to treatment once screening results were returned but there was a need to improve the initial screening time.

During our inspection we carried out a review of patients who had been screened for sepsis as a result of an increased national early warning score (NEWS). We found 55% of patients with a NEWS score at the trust’s escalation threshold had been screened for sepsis within 60 minutes. We asked the critical care outreach team about the remaining 45% who told us these patients were included in an ongoing daily audit to ensure the reason for not screening for sepsis was clinically appropriate.

As part of the trust’s work to improve sepsis screening and management, each ward had a sepsis box. The hospital sepsis lead nurse practitioner had delivered training to all ward-based teams on the use of the boxes and implemented new e-learning. The sepsis practitioner had established simulated patient profiles on the electronic monitoring system so that staff could develop their skills in identifying risks. This training was delivered to all clinical staff and where individuals returned from leave they were allocated protected training and learning time.

Staff used a national early warning scores (NEWS) to monitor medical deterioration. The trust monitored the correct completion of the clinical observations through a monthly audit. This established standards of care in each ward or clinical area against trust standards. Between November 2016 and October 2017 average compliance with all observations was 77%. This was an average figure and reflected a monthly range between 68% and 84%. Performance between individual wards also varied. The stroke unit and Ashby ward achieved or exceeded the trust standard of 90% for at last eight months during this period. Ingham ward met the trust standard for three months during this period and the remaining wards did not meet the standard in any month. Carlton Coleby ward demonstrated the most significant need for improvement, with 52% overall compliance from January 2017 to October 2017. Although this ward demonstrated a 25% improvement during this period, compliance with trust standards remained comparatively low. Although there were month-on-month improvements within this period these were not consistent
or sustained. We found consistent completion of NEWS observations in all areas during our inspection.

Patients with an increasing NEWS score, which represented deterioration of their condition, were identified automatically on the electronic patient monitoring system. This system alerted the critical care outreach team (CCOT) as an escalation of care who then attended to the patient as a priority. Overnight the system alerted the site practitioner and hospital at night coordination centre. This team then identified the most appropriate clinician to assess the patient, such as the CCOT nurse or duty registrar.

We looked at a sample of six records on Waddington ward for patients receiving haematology-oncology treatment. In each case we found evidence staff were proactive in escalating patients with increasing NEWS scores. This included coordinating care with CCOT and the hospital intervention team.

During our observations of handovers, we noted staff reviewed risk assessments and NEWS scores in detail and confirmed that the correct care pathways were in place. For example, we observed nurses on Burton ward discuss the management of a patient who had been diagnosed with sepsis in line with the trust’s sepsis policy and the national Sepsis 6 standard.

Staff used a discreet coding system on a board above each patient’s bed to identify which risk assessments needed to be updated and how often. This acted as a reminder to staff to complete or update risk assessments such as body maps for patients with low skin integrity or to complete weight checks for patients at risk of malnutrition.

Staff in the Ingham suite ensured patients who used the walk-in service were risk assessed using the UK Oncology Nursing Society triage tool. For example, if a patient presented to the service and described feeling unwell staff would carry out basic observations and then escalate care. This included carrying out screens for neutropenic sepsis.

All of the staff we spoke with were positive about the responsiveness of the clinical teams who assessed deteriorating patients when they had an increasing NEWS score. However, staff on Waddington ward said they often found it more difficult to get help for medical outlier patients accommodated in the escalation bay on this ward. Although a consultant carried out a review of each patient three times each week, nurses said that if a patient in this bay deteriorated there was often a delay in getting help.

Medical registrars handed over to the hospital at night (HaN) team at 8pm daily. This ensured patients who were deteriorating were confirmed to the night team and meant they could continue to monitor them. Overnight the hospital had capacity to support deteriorating patients in addition to the HaN team; through a nurse coordinator, a foundation level doctor, a nurse practitioner with extended skills and the hospital intervention team. This team was led by clinicians with high levels of interventional skill.

Staff in the cardiac catheter laboratory used the World Health Organisation (WHO) surgical safety checklist; this had been adapted specifically for invasive cardiac procedures. We observed the WHO process being carried out during our inspection and found all team members engaged appropriately. The WHO process ensures that each stage of the patient’s journey is managed safely.

Staff used an electronic tracking system to identify patients who had been admitted to wards as ‘outliers’. This occurred when the specialty in which they would be treated had no available beds. Staff in all wards told us this happened frequently but the tracking system enabled doctors to identify their patients and ensured they carried out regular reviews. We found nursing staff were
confident in challenging inappropriate outlier admissions. For example, one nurse challenged an outlier admission where the patient was delirious and confused and in another instance a nurse challenged an outlier admission where they felt the patient could not be safely cared for on the ward.

Prior to our inspection we had ongoing concerns about the care and treatment of diabetic patients on Navenby ward. The trust had taken a number of actions based on our ongoing dialogue. During this inspection we visited Navenby ward to review actions the trust had taken.

We reviewed the care of eight diabetic patients on Navenby ward. All patients had their blood glucose (BM) monitored on a regular basis. When BM was high we saw how ketone monitoring had taken place. We saw appropriate interventions such as administering of insulin when the blood glucose was high.

We saw how patients had been reviewed daily by diabetic nurse specialists and had specific diabetes inpatient assessment plans.

We saw good care of a patient who had an insulin pump and saw documented evidence of how nursing staff had professionally challenged a medical team’s decision to stop the insulin pump.

Diabetic nurses visited the ward daily and provided support for patients and staff in the care and treatment of diabetic patients.

A mental health liaison team was available in the hospital during daytime hours and out of hours staff said they would contact local crisis teams for support or patient review.

Consultants were available seven days a week, which meant patients were seen within 14 hours by a senior clinician in line with the London Quality Standards.

Critical care beds with full ventilator support were available on site.

There were care pathways in place for patients seen in the endoscopy unit or in radiology who were unwell and needed admission.

From looking at patient records we saw completed appropriate risk assessments and risk management plans for patients receiving non-invasive ventilation and tracheostomy care.

**Nurse staffing**

The trust has reported their staffing numbers below for the period October 2017 for medicine. There are 122 less nursing staff in place within the medicine core service than was planned to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln</td>
<td>353.87</td>
<td>298.75</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 18.7% in medicine; the target for the trust was 11.5% for registered nurses and midwives

- Lincoln County Hospital: 17.6%

(Source: Routine Provider Information Request (RPIR) Vacancy)
Turnover rates

From November 2016 to October 2017, the trust had a turnover rate of 8.3% in medicine; compared to the trust target of 7% and no staff group more than 20% above the target.

- Lincoln County Hospital: 7.6%

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

Sickness rates

From October 2016 to September 2017, the trust reported a sickness rate of 5.28% in medicine; compared to the trust target of 4.5%

- Lincoln County Hospital: 5.4%

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

Bank and agency staff usage

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 20.3% with a further 4.8% of shift remaining unfilled. A breakdown by staff type and location is shown below:

Lincoln County Hospital

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>6,613 (13.1%)</td>
<td>3,146 (6.2%)</td>
<td>1,738 (3.4%)</td>
<td>50,476</td>
</tr>
<tr>
<td>Unregistered</td>
<td>6</td>
<td>6,012 (26.3%)</td>
<td>2,098 (9.2%)</td>
<td>22,897</td>
</tr>
</tbody>
</table>

From December 2016 to November 2017 the trust reported a bank and agency usage within medicine as below:

- Lincoln County Hospital had a total of 16,446 shifts, bank staff covered 7,599 and agency staff covered 5,819 which left 3,028 not covered.

(Source: Routine Provider Information Request (RPIR) Nursing bank agency)

An electronic safe care staffing tool was in place to help the site team identify patients with high levels of acuity and to arrange staffing accordingly. For example, we saw Burton ward had two patients who were hyper-calcaemic (raised levels of calcium in the blood) and so the site team needed two permanent trust nurses in the ward overnight.

Agency nurses completed a comprehensive, documented induction before they were able to practice on the wards and take responsibility for individual patients. Agency nurses were also required to provide evidence of competencies or certification for administering intravenous medicine and complete an assessed observation by the ward sister or matron. The matron for each clinical area audited the completion of agency nurse induction checklists on a quarterly basis and cross-referenced this with the information held by the temporary staffing team. We looked at a sample of 17 agency nurse checklists across five wards and found them to be fully completed with evidence of initial supervision by the nurse in charge. However, the investigation into a serious
incident at another hospital in the trust in 2017 found that agency nurses may not have up to date understanding of fire safety procedures despite this being an integral part of the induction. This meant we were not assured the induction checklist process was fit for purpose.

At times of high escalation, the hospital by exception used a ‘hub’ model to allocate agency nurses to individual wards. This meant agency nurses reported to a central office and were then allocated to wards based on planned staffing needs. Most of the ward nurses we spoke with were critical of this system and said it resulted in handover delays of up to 30 minutes while waiting for agency nurses to arrive from the central office. Following our inspection, the trust told us the vast majority of agency nurses are booked to a specific area against a vacancy.

We reviewed daily nurse staffing levels on each ward we inspected and did not find that these were always sufficient to keep patients safe. For example, on one day on Burton ward there was one nurse in charge, three staff nurses (including one agency nurse), three healthcare assistants and one associated practitioner. Patients on this ward had highly complex needs and often needed one-to-one nursing care. This was also a mixed-specialty ward, for elderly patients and for those with renal needs. Staff told us they regularly finished their shift late because the complexity of patient’s needs combined with low levels of staffing meant it they had more work to do than could be completed within the shift times. Overnight a band five staff nurse took responsibility for the ward and each patient and often worked with an agency nurse of the same grade who often lacked the training to deliver safe care.

As part of our inspection we observed nurse handovers on Burton ward and Lancaster ward. Both handovers were very detailed and nurses discussed each patient’s daily living needs as well as their clinical status and social needs. Nurses on both wards demonstrated excellent attention to detail in relation to risk assessments such as the SSKIN bundle, frailty assessments and for bed rails. We saw there were in-depth discussions of multidisciplinary care needs and plans including which patients were waiting for assessments and when the referrals had taken place. Healthcare assistants (HCAs) did not join handovers and were given a pre-printed handover sheet instead. We spoke with three HCAs about this who said the process helped ensure they could support patients with breakfast and getting out of bed where possible, which reduced delays and meant nurses had more time for detailed handovers.

A nurse consultant, a team of nurse endoscopists and senior staff nurses provided the endoscopy service.

A nurse coordinator and team of staff nurses led care on the Ingham suite, which provided a chemotherapy day case service. This unit operated with a nurse to patient ratio of 1:5 and a team of HCAs provided support. The unit also had a policy of not using agency nurses so that the senior team could maintain close oversight of the skill mix of each shift. This ratio was not typical of inpatient wards, were the ratio of nurses to patients was much lower. On Lancaster ward the ratio was 1:10 and patients were accommodated in a combination of bays and side rooms that were a considerable distance apart.

A senior nurse on Waddington ward told us they were fully staffed about 70% of the time and that the site team frequently redeployed planned nurses from the ward to other areas of the hospital. Clinical staff in multiple areas spoke similarly and said they often accepted working under the minimum number of nurses per shift because of the risk of staff being redeployed elsewhere. Nine staff we spoke with said this had a detrimental effect on the team and increased pressure and reduced morale. They told us it also meant staff were less willing to work overtime on bank shifts as a result. This presented a significant risk to the service as short staffing in nursing teams was an item on the business unit risk register. The risk cited a 40% vacancy rate on Navenby ward and
in the frailty assessment unit, a 30% vacancy rate on Scampton ward and Carlton Coleby ward and a 20% vacancy rate everywhere else. This was not a sustainable staffing model and the redeployment of staff was an interim measure to help prevent risks to patients or the closure of beds.

Our conversations with patients and relatives reflected on the working culture of the hospital as patients described engaged teams but noted they often felt worried by how busy and rushed staff were. For example, one patient said, “I feel safe but the staff work ridiculously. They never, ever have time to stop and this makes me worry about them.” Another patient said, “I don’t think it’s unsafe but it has stopped me asking for help for things like the toilet or another drink. I’d feel bad when they’re so busy rushing about.” One patient said, “It would be nice to be able to have a chat with staff sometimes but you’re lucky to get five minutes with them all day, they’re just so busy. I asked a nurse for a coffee yesterday and they said, “Yes but only if I have time”.”

Although patients who spoke about the workload of staff were in various clinical areas, patients on Lancaster ward most frequently commented on this. One patient said, “It takes a long time for a nurse to come if I use my call bell. I don’t mind, I can see them rushing about, but it means I need to think ahead to be able to use the toilet.” Another patient said, “I try not to ask for things during the night, the night nurses are far too busy. I felt dizzy last night and asked one of the nurses for help and they said, “Do it yourself, I’m too busy.” The night before I’d asked for a drink after I went to bed but it never arrived; they just seemed to be too busy.”

Medical staffing

The trust has reported their staffing numbers below for the period October 2017 for medicine. There are 43 less medical staff in place within the medicine core service than was planned to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln</td>
<td>131.61</td>
<td>110.82</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate of 16.8% in medicine; against a target of 12% for medical staff

- Lincoln County Hospital: 15.4%

(Source: Routine Provider Information Request (RPIR) Vacancy)

Turnover rates

From November 2016 to October 2017, the trust a turnover rate of 8.3% in medicine; compared to the trust target of 7% and no staff group more than 20% above the target.

- Lincoln County Hospital: 7.2%

(Source: Routine Provider Information Request (RPIR) Turnover)
Evidence appendix United Lincolnshire Hospitals NHS Trust

Sickness rates

From October 2016 to September 2017, the trust reported a sickness rate of 2.59% in medicine; compared to a trust target of 4.5%.

- Lincoln County Hospital: 3.3%

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

Bank and locum staff usage

This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) Medical agency locum)

Staffing skill mix

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

Staffing skill mix for the 210 whole time equivalent staff working in medicine at United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</td>
<td>23%</td>
</tr>
</tbody>
</table>

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

Source: NHS Digital - Workforce statistics (01/08/2017 - 31/08/2017)

A haematology consultant led a ward round on Waddington ward Monday to Friday and on Saturday and Sunday a ward round was led either by a consultant or a specialist registrar. A consultant was always on call for the haematology-oncology service and a specialist registrar provided daily cover including for medical outliers. Junior doctor cover for the ward was variable and staff told us there was often only one junior doctor on shift to cover all 21 patients. A middle grade doctor provided care for patients in the Ingham suite and for haematology outliers who were admitted elsewhere in the hospital when the dedicated wards were at capacity.

A consultant in complex care led the care and treatment of medical patients on Burton ward and was supported by a specialist registrar and two foundation level doctors. This ward also provided care for renal patients, whose care and treatment was led by a renal consultant, a specialist
registrar, a foundation level doctor and a senior house officer. The teams were available Monday to Friday between 9am to 5pm and outside of these hours complex care patients were cared for by senior house officer in the medical assessment unit and a specialist registrar provided on-call cover. We were not able to establish the out of hours cover for renal patients from the team on site during our inspection. Following our inspection, the trust told us there was a full seven day on call rota provided by renal physicians, with telemedicine provided by Leicester if any rota gaps occurred.

One care of the elderly consultant and one locum consultant delivered this service Monday to Friday from 9am to 5pm. A team of specialist registrars were based on Scampton ward and provided cover to patients on Lancaster ward on demand. Two consultants covered Scampton Ward and 2 Consultants covered Lancaster Ward. In addition, a GP trainee provided elderly care to inpatients. Consultant cover at weekends was through an on-call system and if the consultant was running a clinic then ward rounds were led by foundation level doctors. Clinical staff on care of the elderly wards told us medical cover fluctuated and could be unpredictable. A senior clinician told us medical cover on a typical weekday was usually two foundation level two doctors plus a GP trainee or foundation level one doctor. They said specialist registrars were available for the most complex needs only and described the team as “stretched” and said that the combination of scheduled ward rounds and deteriorating patients meant the team often did not have time to fully review all patients. Although a senior house officer was assigned to care of the elderly services, long term sickness meant this post had not been covered for several weeks.

At weekends there were ward rounds provided to Burton and Scampton wards by renal physicians. Lancaster Ward had no formal ward rounds at weekend but had on call cover. Junior doctors did not undertake formal ward rounds without seniors.

One full time consultant and three locum consultants led medical cover on the stroke unit. There was no specialist registrar on this unit and two foundation level doctors provided daily cover along with a GP trainee. Between 5pm and 9pm a foundation level doctor covered the stroke unit and two inpatient wards and at 9pm the HaN team was available. Clinicians on the stroke unit we spoke with said this level of cover felt safe and they felt well supported by the consultant.

A specialist registrar provided on-call support to the nursing team in the Ingham suite and was available to review unwell patients and to issue to take away prescriptions for patients who used the walk-in service. A consultant was also available in the outpatient clinic and provided support when needed.

A haematology consultant was based on Waddington ward Monday to Friday and provided an on-call out of hours service at weekends. A haematology specialist registrar was based on the ward weekday daytimes and at other times medical care was provided by foundation level doctors. Out of hours the MAU registrar was on-call for the ward although staff told us it was often difficult to get a doctor’s review out of hours unless it was an emergency.

Consultants on Navenby ward covered a two-week period on the ward this ensured patients had continuity of care.

Medical cover between 10pm and 8am was provided by two foundation level doctors plus a specialist registrar. There was also a twilight foundation doctor working until 12pm and a twilight medical registrar until 1am. Thirteen members of staff we spoke with said obtaining doctor assessments overnight was problematic. One senior nurse said, “They cover a phenomenal number of patients and they’re very difficult to reach. We often put out calls to the site team for doctor support but we never get it.” On one day of our inspection we found a nurse from Lancaster ward had to leave a single nurse on this unit whilst they walked to the emergency department to
speak with a doctor there about prescribing urgent medicine for patient. This was because the doctors on shift for medical care were too busy to visit the ward. This presented a significant risk to the sole nurse left on the ward during this time. We raised our concerns at the time of our inspection.

Records

Most clinical areas used paper notes for patient records and observations. The chemotherapy service used a standalone electronic system and all areas used an electronic tracking system to identify the location of patients and NEWS status.

The trust carried out two audits on patient records in 2017 to establish compliance and standards against 36 standards set by the NHS Litigation Authority and using the Academy of Royal College record keeping tool. Medical inpatient services and the stroke service were audited twice and the AMU was audited once. Overall results were highly variable and there was little evidence of improvements as a result of the audits. None of the clinical areas achieved the trust minimum standard of documenting the patient’s NHS number and their first and last names on every page of their record. Performance in this measure was significantly below standard in the stroke service, which demonstrated 61% compliance in the second audit. This represented score 32% worse than in the first audit.

The audits found a deterioration of standards in medical care for eight measures between audits including a 15% decrease in the patient records with times of entry recorded and a 30% decrease in full documentation about the prescribing of antibiotics. In the stroke service, legibility for the issuing of prescriptions and documentation of antibiotics both decreased by 50%. Deterioration was noted in some essential and basic elements of patient records, such as an 11% decrease in the number of patients with both their first and last names recorded. Medical wards improved standards in five measures between audits and the stroke service improved in two measures. In each audit services achieved the target of 100% in between eight measures and 15 measures.

All services achieved 100% of the trust standards for seven total measures in all of the audits, including in the documentation of patients ‘do not attempt resuscitation’ (DNAR) status and clear recording of referrals and investigations.

The auditor made 10 recommendations following both audit cycles. This included wider publication of record keeping standards and requirements, sharing of results between specialties and the implementation of a trust action plan to improve overall compliance.

Medicines

A pharmacist was dedicated to the haematology-oncology service and staff told us if this individual was unavailable due to holiday or sickness then the hospital was not able to provide cover in most instances. A clinician told us this meant chemotherapy was sometimes delayed as was other medicine dispensing due to a lack of capacity in the pharmacy team.

We observed a medicine round on Burton ward and found the nurse demonstrated attention to detail and an excellent safe standard of practice. This included a full check of each patient’s identity wrist band, allergies documentation and previous completion of the medication administration records (MARs). We observed staff in the Ingham suite and noted they obtained consent from each patient before inserting a cannula and starting intravenous medicine and checked each patient’s identity and allergy status before beginning. Staff recorded the batch number and expiry date of each IV bag electronically and used the appropriate aseptic non-touch technique (ANTT) process. During both of our observations we observed staff adhere to hand hygiene best practice standards.
We reviewed medicine storage and safety processes in the Ingham suite and on Waddington ward and found these to be in line with trust policy and national standards. This included the locked storage of controlled drugs (CDs) with restricted access and daily documented checks of stock signed by two nurses. Although medicines were stored securely the stock control process in the Ingham suite was not always effective. For example, we found seven items that had expired, including two nebulisers that had expired over two years ago. We spoke with a nurse about this who said these were rarely used items and so would not be immediately obvious on a stock check for more regular items. The policy used by staff in the Ingham suite to ensure medicine fridges remained within a safe temperature range had been due for review in January 2017, which meant it was 13 months out of date. The lead nurse said they would escalate this and find out why it had been delayed.

Chemotherapy was stored separately in locked fridges and staff had documented daily temperature checks. We found no gaps or missing records in the previous six months and staff had noted when the maximum temperature had been exceeded. This happened when the fridge door was open so staff could prepare chemotherapy. Although staff in the Ingham suite recorded the temperature of the storage room for medicines they did not know the acceptable range of temperatures. This meant we were not assured corrective action would be taken in the event the temperature exceeded the manufacturer’s safe maximum.

Nurses in the Ingham suite and on Waddington ward were trained to prescribed antibiotics for sepsis and neutropenic sepsis against patient group directions (PGDs). PGDs provide a framework that enables trained, qualified health professionals to administer specific medicines to a pre-defined patient group. This reduced delays in waiting for a doctor or nurse prescriber to administer medicines, which meant patients started treatment more quickly.

We observed staff on Carlton Coleby ward use appropriate encouragement with patients who found it difficult to swallow pills or who were nervous about using eye drops. We saw staff were patient, explained why the medicine was important and helped patients explore ways of taking these more easily.

Three medicines ambassadors were in place on Burton ward and worked to improve medicines safety by promoting the use of an eight-stage process to provide staff with a framework for medicine administration.

We looked at a sample of MARs on Lancaster ward and found the pharmacist had highlighted a number of errors in the documentation. For example, staff had not completed the clinical indication for five PRN medicines for one patient and there were seven missed doses without a reason code. In addition, the patient’s NHS number and full name had not been recorded on any sheet of the MARs, other than the first page. The pharmacist had noted that staff had not recorded a patient’s weight on admission and indicated this must be completed. However, there was no update to the documentation three days later.

At our last inspection we had concerns around the preparation and security of medicines in the cardiac catheter lab. At this inspection we found that appropriate action had been taken. Medicines were secured securely and a new process had been implemented with regards to the preparation of medicines. Two nurses now prepared and checked medicines which were to be used during procedures. These were appropriately recorded.

The cardiac catheter lab used a closed fluid system on the procedural trolley. This was line with best practice and reduced the risk of patients inadvertently receiving wrong fluids and or medications by the wrong route.
At our last inspection on Johnson ward we found two medicines trolleys which should have been secured to the wall behind the nurses’ station. These trolleys were not secure. We found the same issue at this inspection. We raised this with the nurse in charge, who took action to secure them. We were therefore we were not assured that sufficient actions had been taken to address and embed actions as a result of this concern.

There had been a serious drug error on Johnson ward prior to our inspection. We were told that one action to learn from this incident was that all infusion pump rates were checked at each hand over and when replacing the infusion medicine. We observed the care of patient receiving an IV infusion. We saw that on each occasion when care had been handed over, two nurses had signed to check the infusion was running at the correct rate. However, we found on one occasion when the infusion was changed no second check had been performed by another nurse. The infusion had been running for approximately 30 minutes. We raised this immediately with nursing staff who took action to check the infusion. We were not assured that actions taken as a result of the drug incident had been sufficiently embedded in practice.

**Incidents**

**Never Events**

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

From December 2016 to November 2017, the trust reported one incident classified as a never event for medicine.

This never event took place in August 2017 at the Pilgrim Hospital Boston site, and related to a lumbar puncture on the wrong patient on the Acute Medical Unit.

![Graph showing surgical invasive procedures and incident meetings]

*Source: NHS Improvement - STEIS (01/12/2016 - 30/11/2017)*

After this data was released the trust reported a never event that related to a patient death as a result of a misplaced nasogastric (NG) feeding tube at the Pilgrim site. This was an avoidable event had staff had appropriate training and competencies. Following this the trust implemented a substantial improvement programme. This included the new staff competencies and restrictions on who could insert, manage and monitor NG tubes. They also carried out a rapid review of all national guidance and standards for the use of NG tubes to provide assurance their policies reflected these. In addition, quality matrons were establishing a new audit process to ensure the practice of using NG tubes was continually monitored. This had been rolled out trust wide.

**Breakdown of serious incidents reported to STEIS**
In accordance with the Serious Incident Framework 2015, the trust reported 137 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported were:
- Pressure ulcer meeting SI criteria with 50 (37% of total incidents).
- Slips/trips/falls meeting SI criteria with 30 (21% of total incidents).
- Treatment delay meeting SI criteria with 19 (13% of total incidents).
- All other categories with 15 (12% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 12 (9% of total incidents).
- HCAI/Infection control incident meeting SI criteria with 11 (9% of total incidents).

Site specific information can be found below:
- Lincoln County Hospital: 52 incidents

(Source: Strategic Executive Information System (STEIS))

Between April 2017 and March 2018, the security team submitted three incident reports relating to issues on medical wards and ward staff submitted 12 reports of instances in which the security team had been called. In most instances it was noted security officers were able to deescalate the situation or assist clinical staff by working with the patient on a one-to-one basis until they calmed down or until staff could issue appropriate medicine. One incident report noted six members of staff were needed to restrain a patient who became violent during a night shift when there were no security officers on shift.

Staff we spoke with in the endoscopy demonstrated a good understanding of the incident reporting system and were able to discuss recent serious incidents in detail. In addition, we saw an example of the patient safety briefing sent out by the business manager and patient safety group to all staff after an incident investigation had been concluded. This meant all staff in the service were including in learning and action plans for improvement.

Staff in the Ingham suite had reviewed local policies on the treatment of patients who received NG feeding following the outcomes of the never event. The service rarely saw patients with this treatment and had not seen it in the previous 10 years. However, the senior team ensured all nurses understood the policy and were aware of how to deliver care in line with learning from the never event.

Staff on inpatient wards demonstrated a clear understanding of the never event and senior nurses had worked to ensure each member of their team had updated competencies.

Following a fire at the trust’s Pilgrim site, staff had undertaken more intensive fire safety training. This included simulated evacuations and competency assessments on the use of evacuation equipment, such as chairs used in vertical evacuations. Staff who had completed this training spoke positively about it although not all staff had yet completed it. For example, nine members of staff on Dixon ward had out of date fire training. Although staff told us they felt better prepared for an evacuation they said the trust had not communicated specific learning from the fire with them.

Staff on Waddington ward had reported two serious incidents relating to hospital-acquired pressure ulcers. As a result, new processes had been implemented to reduce the risk of similar occurrences. This included the introduction of daily pressure check forms and the inclusion of skin integrity checks on patient admission forms.

Safety thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported 61 new pressure ulcers, 71 falls with harm and 11 new urinary tract infections in patients with a catheter from December 2016 to December 2017 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at United Lincolnshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Total Pressure ulcers (61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Falls (71)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total CUTIs (11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.30</td>
</tr>
</tbody>
</table>

*(Source: Safety thermometer - Safety Thermometer)*

Each ward used a safety and quality noticeboard to indicate their track record of operating without a hospital-acquired pressure ulcer (HAPU). For example, staff on Lancaster ward had not reported a HAPU for over 365 days. Where wards had experienced HAPUs or a falls incident, this was displayed along with the action taken.

**Is the service effective?**

**Evidence-based care and treatment**

Care and treatment pathways and policies regarding specific types of treatment were based on national best practice guidance and standards. For example, the policy for initiating non-invasive
ventilation (NIV) was based on clinical guidance from the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians and the British Thoracic Society.

The trust benchmarked assessments and prescribing for venous thromboembolism (VTE) against NICE clinical guidance 92 and used an auditing and quality governance process to identify areas of good performance and areas for improvement. Audits took place in two cycles twice each year and assessed care and treatment of patients against 12 criteria. The most recent results were published in March 2018 and found overall compliance to be 68% in cycle one and 78% in cycle two. These were average figures and reflected a wide range in performance in each measure from 3.3% to 100%. Overall 97% of patients had a VTE risk assessment completed on admission and completed appropriately and 57% of patients were reassessed by a senior clinician within 24 hours. In 100% of cases pharmacological prophylaxis was prescribed in line with national guidance and was given as prescribed in 96% of cases. The key improvements identified from the latest results noted a need to implement more timely re-audits and actions based on the 'plan, do, study, act' (PDSA) cycle.

Therapies teams led audits specific to each specialty. In 2017/18 the audit plan reflected a range of audits to benchmark care and treatment against national quality standards as well as to understand and improve patient experience and outcomes. This included four occupational therapy audits, six physiotherapy audits and one dietetics audit. Audits to benchmark care included for hip fracture treatment and osteoarthritis treatment, both in line with NICE guidance. To improve patient assessment and care, a dietician was leading an audit to improve the management of oncology referrals to the service.

In 2017/18 there were 46 active audits in medical care services made up of 24 national audits, 19 local audits and three re-audits. The audit programme reflected contribution to a significant range of national benchmarking and accreditation bodies. The programme also represented the hospital’s drive to continue improving care standards and outcomes through practice that represented the latest knowledge on the specialty. Local audits were representative of the needs of the local population. For example, one audit was in place as part of a frailty in reach improvement project and another was being used to assess the efficacy of mental health services for patients on elderly care wards.

The endoscopy unit was accredited by the Joint Advisory Group (JAG) for GI Endoscopy. This meant care, treatment and procedures were had been assessed to be delivered in line with international best practice standards and were regularly assessed and audited. The accreditation was an indicator of high quality performance and standards in line with those set by the international global ratings scale.

Staff in the frailty assessment unit used a screening tool based on best practice guidance from Healthcare Improvement Scotland to ensure patients received the most appropriate evidence-based care.

The nurse in charge of each ward ensured a rolling programme of local audits was completed, with support and governance oversight from the matron. The programme included nine core audits such as infection control, medicines management, counting compliments and a ward lead assurance audit. Staff in the Ingham suite demonstrated good awareness of learning from audits. For example, one audit identified a need for improvements in waste management when personal protective equipment was found in an incorrect bin. In addition, audits indicated a need for staff to be more consistent in the recording of patients’ weight, which the team told us helped to remind them.
In the cardiac catheter laboratory, we saw LoCSIPPS had been implemented in line with national guidance. LoCSIPPS aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur they are derived from National Safety Standards for Invasive Procedures (NatSSIPs)

**Nutrition and hydration**

A trust lead dietician led a team of eight dieticians, two dietetic assistants and a diabetes specialist. Specialist team were also in place for neuro-rehabilitation and community nutritional support and a mental health specialist dietician was available for support from another NHS trust. A renal dietician was dedicated to this specialty and supported staff with nasogastric (NG) feeds and percutaneous endoscopic gastronomy (PEG) feed care.

A community and home enteral nutrition specialist worked within the dietetics team. This team worked closely with the speech and language therapy team and provided continual support for patients when they were discharged into the community with modified diets or with prescribed supplements.

The dietetics team had broadened the criteria for providing care to patients who had experienced a stroke, based on the malnutrition universal scoring tool. Between August 2017 and November 2017 78% of patients had been screened for their nutritional needs and been seen a by a dietician, compared to the national average of 81%.

In the 2017 national patient-led assessment of the care environment (PLACE), inpatient medical wards scored 91% for food and hydration, which was a significant improvement from the 82% score achieved in the 2016 PLACE results.

We found evidence of nutrition, elimination and swallowing risk assessments and care plans for patients on Waddington ward. In each case they were comprehensive and had been regularly reviewed by multidisciplinary professionals. This included completed and up to date malnutrition universal scoring tools (MUSTs) and waterlow scores.

On Burton ward the ward clerk updated the nutritional information list for the catering team based on each patient’s needs. This meant meals were tailored to each patient and reduced the pressure on the nursing team to maintain contact with catering colleagues.

We asked nine patients on Carlton Coleby ward about food and drinks. Each patient said staff frequently replenished their drinks and it was never a problem to ask for more choices. They also spoke positively about meal options and said they felt the choice and quality were good. However, three relatives we spoke with said they often found water and juice jugs to be out of reach of patients and they had visited previously to find their family members thirsty. One relative said staff had asked them to come in at mealtimes to help their family member eat because they were too short staffed to support them.

Housekeeping and domestic staff on Lancaster ward showed us how they tracked individual needs according to a red, amber, green risk system. This helped them to plan each meal service in line with individual levels of need. Each patient also had an individual menu card that identified specific dietary needs such as blended or soft diets. Patients who needed one-to-one support to eat were served their meal last, which meant food stayed hot whilst staff served other patients.

We observed the lunch service on Lancaster ward and found staff were in significant demand due to the number of patients who needed one-to-one support to eat. Four patients slept through the
lunch service and their hot food was not saved. Staff told us they would use the pantry on the ward to prepare food for them when they woke up.

Housekeeping staff on Burton ward had developed a fluid ambassador role as part of a project with the renal consultant to develop training and a framework for the whole ward team to improve fluid management.

Following feedback from patients, staff on Lancaster ward provided finger food for patients living with dementia. This meant they could snack at any time, including if they were walking around the ward, and reduced the risk of malnutrition because they could not eat a full meal at a specific time.

We looked at a sample of three fluid balance charts on Lancaster ward and found completion to be sporadic. For example, one patient had four noted episodes of fluid intake over a four-day period but their care plan indicated staff needed to check this hourly. This meant we were not assured the patient had sufficient fluid intake or monitoring. We reviewed five fluid balance charts on Johnson ward and found them to be up to date and calculated correctly. On Ashby ward staff had noted that a patient needed nutritional intake charts completed daily. However, over a three-day period staff had not fully completed any charts, which meant it was not possible to identify if the patient had sufficient nutritional intake. We also found gaps and inaccuracies in the completion of waterlow scores on Ashby and Carlton Coleby wards.

Although documentation on Lancaster ward was inconsistent, staff demonstrated excellent understanding of each patient’s nutrition and hydration needs. For example, one patient had been admitted overnight and required a risk feed protocol. However, the admitting doctor had not completed this and nurses were exploring other options for the patient until they found a doctor to complete the paperwork. In another instance on this ward nurses during handover discussed their findings that a patient who they previously thought was refusing to drink would do so if they held a cup to their mouth.

Pain relief

Staff had documented clear pain management plans in 30 of the 36 records we looked at. Staff used an as-needed (PRN) medicine protocol to ensure patients had regular pain relief and we saw this was documented in their records.

We asked all 42 patients we spoke with about their pain management. In all cases patients told us they felt staff were responsive to their pain needs and regularly asked them about this.

A dedicate pain team was available in the trust and all of the staff we spoke with knew how to contact them, for instance if they needed additional support for a patient with complex needs.

Patient outcomes

Relative risk of readmission

Trust level

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

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

Non-Elective Admissions – Trust Level

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Lincoln County Hospital

From September 2016 to August 2017, patients at Lincoln County Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average. However, the following specialties were higher than expected for elective admissions:

- Patients in clinical oncology (previously radiotherapy) had a higher than expected risk of readmission
- Patients in gastroenterology had a higher than expected risk of readmission

Elective Admissions - Lincoln County Hospital

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

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in the latest audit, April to June 2017 for Lincoln County Hospital. This is an improvement from the last audit completed in December 2016 to March 2017. There were six patient centre domains as well as six team centred domains that improved on their score.

However, the score relating specifically to the stroke unit at Lincoln County Hospital is level D, worse than average. The main factor behind this poor score is the proportion of patients admitted to the stroke unit within four hours of the clock start (arrival at hospital or onset of symptoms at hospital).

<table>
<thead>
<tr>
<th>Lincoln County Hospital</th>
<th>Patient centred Performance</th>
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<tbody>
<tr>
<td></td>
<td>Oct-Dec 15</td>
</tr>
<tr>
<td>Domain 1: Scanning</td>
<td>B</td>
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<tr>
<td>Domain 2: Stroke unit</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C↓</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>D</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>B↓</td>
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<tr>
<td>Domain 6: Physiotherapy</td>
<td>C↓↓</td>
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<tr>
<td>Domain 7: Speech and language therapy</td>
<td>B↓</td>
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<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>B↑</td>
</tr>
<tr>
<td>Patient-centred Total Key Indicator Level</td>
<td>C↓</td>
</tr>
</tbody>
</table>

Team centred Performance
After our inspection the trust provided more up to date SSNAP data relating to August 2017 to November 2017. This indicated a continuation of the hospital’s good performance in this audit. The hospital achieved a grade B for team-centred indicators, a grade A for case ascertainment band, a grade A for audit compliance band and an overall grade B. The trust had implemented a remedial action plan to address areas of underperformance in the audit, such as the development of a specialist stroke nurse coordinator role.

The national standard is that patients who experience a stroke spend at least 90% of their inpatient stay in a specialist stroke unit. Between August 2017 and November 2017, the hospital achieved 85%, which was similar to the 86% national average. Also during this period 80% of patients were admitted directly to the stroke unit, which was better than the national average of 59%.

The hospital monitored care based on the RCP national clinical guidelines for stroke including in relation to the administration of thrombolysis. Between August 2017 and November 2017, the hospital scored an overall grade B in this measure and performed better than the national average in all four criteria. This included 100% of patients receiving thrombolysis compared with the national average of 88%.

(Source: Royal College of Physicians London, SSNAP audit)
The hospital performed variably against the standard set in NICE quality statement 7 in relation to a daily therapy targets. For example, 34% of patients received the minimum occupation therapy time required against a national average of 87%. For physiotherapy 78% of patients achieved the standard compared to 83% nationally. The speech and language therapy (SaLT) team delivered 66% compliance against therapy standards, which was better than the national average of 53% although only 44% were seen by the team within 24 hours.

The average length of stay for patients being treated for a stroke was 5.3 days less than the national average, reflecting targeted work to improve this.

**National Diabetes Inpatient Audit**

**Lincoln County Hospital**

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

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

The 2016 National Diabetes Inpatient Audit identified 82 in-patients with diabetes at Lincoln County Hospital, 95.6% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile four.

The average number of diabetes specialist nursing hours (DISNs and DSNs) spent providing inpatient care per week per diabetes patient saw in Lincoln County Hospital, on average 0.26 diabetes specialist nursing hours per week were spent with each patient in 2016, which places this site in Quartile 1.

4.9 per cent of patients with diabetes in Lincoln County Hospital were admitted with active foot disease in 2016, which places this site in Quartile 1.

In Lincoln County Hospital in 2016, 100.0 per cent of patients with diabetes admitted with active foot disease were seen by the multidisciplinary diabetic foot team (MDFT) within 24 hours, which places this site in Quartile 4.

(Source: NHS Digital)

**Myocardial Ischaemia National Audit Project (MINAP)**

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

From April 2015 to March 2016, 59.1% of nSTEMI patients were admitted to a cardiac unit or ward at Lincoln County Hospital and 100% were seen by a cardiologist or member of the team compared to an England average of 55.8% and 96.2%. The proportion of nSTEMI patients who were referred for or had angiography was 91.1% compared to an England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))
Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 1.0%, which was does not meet the audit minimum standard of 90%. The 2015 figure was not available.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 16.4%, this was significantly worse than the national level. The 2015 figure was not available.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 58.3%, this is not significantly different from the national level. The 2015 figure was not available.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 48.6%. This is not significantly different from the national level. The 2015 figure was not available. The one year relative survival rate for the trust in 2016 is 31.4%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Lincoln Country Hospital

The crude proportion of patients who had a vision assessment was 100% this met the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 20% (this site was marked with a footnote that above 50% of patients were classed as ‘not applicable’ for the marked key indicator). This was worse than the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 47%. This was worse than the national aspirational standard of 100%.

The crude proportion of patients with an appropriate mobility aid in reach (if applicable) was 50%. This was worse than the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The reliance on agency nurses often meant individual wards could not always deliver care and treatment in a timely manner, which had an impact on patient outcomes. For example, some agency nurses could not carry out blood sugar tests or manage intravenous medicines, which meant care was delayed as the demand on permanent nurses was increased.

Competent staff

Appraisal rates

From April 2017 to October 2017, 66.2% of staff within medicine at the trust had received an appraisal compared to a trust target of 85%.

A split by staff group can be seen in the graph below:
• Lincoln County Hospital had a 64.2% appraisal completion rate.

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

We asked about appraisals in each clinical area we included in our inspection. In the Ingham suite 70% of staff had an up to date appraisal although nurses we spoke with said the ongoing process of discussing training and progress throughout the year meant appraisals did not add significant value to this. We looked at a sample of appraisals and saw they were used to establish planned training completion over the coming year, including for blood cultures, cannulation, venepuncture and the aseptic non-touch technique (ANTT). The team on Burton ward were 100% up to date with appraisals. Senior nurses told us it was not trust protocol to provide newly qualified nurses with regular supervisions and instead the mentor and buddy programme meant they had regular contact and support from a more senior member of the team.

As part of the trust’s sepsis action plan all staff had undertaken a new practical training programme. This had been delivered by a dedicated team on a one-to-one basis or in small clinical learning groups. This was in addition to the introduction of sepsis e-learning to the mandatory training programme.

The head of nurse education led the clinical education team, which included an interprofessional practice learning unit (IPLU) team and a team of clinical education nurses, with support from three dedicated administrators and a secretary.

Respiratory nurse specialists monitored the completion of non-invasive ventilation (NIV) competencies against standards set by the NIV quality and safety improvement group. An NIV competency policy was in place and was due for review in late 2019. In addition, nurses had to successfully complete at least six months post-qualification service prior to beginning NIV training. Not all nurses who worked on the respiratory ward had completed NIV competency training. For example, on one day of our inspection three patients were receiving NIV with only one nurse on shift with their competencies signed-off. Another nurse had completed competency training but was awaiting sign-off. A task and finish group for NIV training had been established and new pathways were in place to help staff deliver safe care. In addition, the divisional leadership team had identified two agency nurses who provided block services to the respiratory ward and had trained them in NIV competencies. This was noted on the divisional risk register as a significant...
risk to the service and the trust acknowledged they were unable to provide two trained nurses 24-
hours, seven days a week.

Assistant practitioners (APs) worked in some wards and had extended roles to supplement the
nursing team and improve patient care. For example, APs were trained in phlebotomy and could
therefore take bloods without needing to wait for a nurse.

Senior staff used a direct observation of procedural skills (DOPS) to assess clinical staff against a
competency scale in specific tasks. We reviewed a sample of 25 DOPS for various clinical
competencies that had taken place in 2017/18. Although each record was completed according to
the competency assessment scale, it was not always evident the assessor identified learning or
areas for further improvement. For example, one DOPS noted the member of staff was assessed
as average (three on a scale of one to five) but the only narrative comment from the assessor was
that this was an excellent effort.

The clinical education team delivered clinical competency workshops for bank staff in
venepuncture and cannulation. In addition, this team delivered a range of specialist workshops on
to HCAs, APs and nurses in 2017/18. The workshops covered 12 subjects or clinical procedures
such as sepsis, ligature training and blood cultures. During our inspection a clinical nurse educator
was working one-to-one with nurses in clinical settings to update ANTT competencies and was
planning to deliver cannulation training the following week. This was representative of the work of
the education team, which included continuous support of ward staff in ensuring they maintained
existing knowledge and continued to develop. Three nurses in the education team worked daily
across all wards to identify opportunities for one-to-one supervision and coaching. This reduced
the need for staff to leave their ward to attend training although also meant the service was limited
in the number of staff it could support at any one time. This was reflected in our conversations with
some staff on Burton ward who said there had been little opportunity for time investment in staff
development because of pressures on the team. In addition, the ward had a dedicated clinical
nurse educator who was required to take patients every shift to ensure they were safely staffed
and had therefore not carried out training or supervision for several weeks.

All staff in the Ingham suite had up to date post-qualification chemotherapy training using national
standards as well as annual updates. We looked at a sample of three national training workbooks
and saw they were fully completed and signed off by an appropriate senior clinician or educator.
Nurses in Waddington ward were also required to complete this training although a period of short
staffing meant not each individual was up to date. Staff told us this was improving and training
opportunities had recommenced following more stability in the team.

Relatives we spoke with on Ashby ward said they felt very reassured by the competency of the
clinical team. One relative said their family member had a tracheostomy and although not all
nurses were tracheostomy trained, they had never had to wait long for a nurse with the
appropriate competencies to provide care.

Staff in the cardiac catheter laboratory had undertaken detailed competencies to carry out the
variety of tasks expected of them in this role such as scrubbing for procedures; this included a
period of supervised practice to embed learning.

Junior doctors told us they felt well supported in cardiology, including in meeting their training
needs. We saw junior doctors receiving teaching on coronary care during our inspection.

All of the staff we spoke with on Navenby ward had a good understanding of diabetic emergencies
and could tell us of learning from a recent serious incident relating to a diabetic emergency. 90%
of staff on the ward had received additional training in the care of diabetic patients and the
remaining staff were scheduled to do this over the weeks following our inspection.
Two clinical nurse educators were dedicated to the endoscopy unit and delivered a rolling programme of accredited training to nurse endoscopists.

Multiple members of the nursing team we spoke with expressed concerns that agency colleagues were often unable or unwilling to carry out critical nursing tasks, such as pressure area care and management. Three nurses on Burton ward told us agency staff would often refuse to carry out certain tasks, such as IV fluids or the administration of antibiotics. Although the divisional leadership team told us such concerns were always acted on, a further 13 nurses and doctors across medical wards told us this was a recurring issue. However, there was some evidence of competency improvements for agency nurses. For example, the senior nurse on Burton ward had worked with diabetes nurses to grant blood glucose monitoring barcode access to agency nurses. They planned this to improve patient safety overnight as agency nurses were not able to take bloods or carry out blood monitoring.

**Multidisciplinary working**

A clinical lead for therapies and rehabilitation medicine (TRM) led a team of physiotherapists, occupational therapists, dieticians and rehabilitation medicine consultants. A site lead for each therapy specialty was in post and dedicated to this hospital. A sister on Ashby ward was a dedicated lead for TRM. A site lead physiotherapist and site lead occupational therapist led individual teams dedicated to wards grouped together by specialty, in addition to the Ashby rehabilitation unit, the stroke unit and the cardiac care unit. In addition, both specialties provided community neuro-rehabilitation outreach services.

A team of eight speech and language therapists (SaLT) worked across medical care services, with specialist SaLT cover dedicated to the stroke unit and to patients with an acquired brain injury. A dysphagia-trained nurse reviewed patients on general medical wards and then submitted a referral to the SaLT team using an electronic system. The team worked with ward clinicians to plan care based on individual need, including through video fluoroscopy assessments.

All 36 patient records we looked at demonstrated evidence of continual multidisciplinary team (MDT) input and contribution to treatment plans. These included evidence of meetings and action plans as well as therapy assessments.

Patients attending the chemotherapy day service had access to all multidisciplinary services in the hospital and particularly relied on Macmillan cancer nurses and dieticians to help them in their treatment plan and recovery.

All of the ward staff we spoke with said the input of the multidisciplinary team was invaluable and most services had a straightforward referral process. For example, they could refer patients to the physiotherapy and occupational therapy teams using an online form and to dieticians by phone. However, several individuals described delays in obtaining a SaLT assessment caused by short staffing in that team. In additional staff on Burton ward said MDT cover for the highly complex care patients often needed did not meet their needs. For example, they said occupational therapy cover was sporadic and their allocated physiotherapist covered 48 beds, which greatly reduced their capacity.

Assistant practitioners provided additional clinical capacity and supported nurses by completing observations and carrying out blood glucose monitoring.

We saw effective MDT working in the cardiac catheter laboratory, with staff communicating effectively inside and outside of the laboratory. This improved the patient experience.
An assertive in reach team worked closely with the frailty assessment unit team to ensure patients spent a maximum of 72 hours on the unit before they were discharged to an appropriate community service or admitted to an inpatient ward.

**Seven-day services**

Consultant cover was provided seven days a week and in some areas, this was through an on-call system. However, staff always had access to a consultant and told us they had never encountered problems in obtaining consultant input. Staff on coronary care told us they had direct access to a consultant cardiologist 24 hours a day and that the cardiology registrar was always available.

Therapies services were provided between 8am and 4pm Monday to Friday with some provision during weekend daytimes and an out of hours referral service at all other times.

The endoscopy unit provided services seven days a week, from 8am to 7pm Monday to Friday and from 8am to 6pm at weekends.

Mental health liaison practitioners were available seven days a week from 8am to 10pm. Outside of these hours a crisis response team was available.

Diagnostic imaging and pharmacy services were available on a 24-hour basis, with emergency on-call cover overnight.

**Health promotion**

We saw from patient records on Waddington ward staff completed detailed medical histories, including involvement with community services for patients with social care needs or who admitted from a social care setting. This meant staff were able to identify health promotion or intervention needs in addition to each patient’s clinical needs as part of their care bundle.

Health promotion information from national stroke organisations was readily available on the stroke ward.

Staff in the endoscopy unit had prepared information boards for conditions such as Barrett’s oesophagus and diverticular disease, which provided information and signposting to patients.

Staff on Burton ward had prepared a health promotion display using an ‘end pyjama paralysis’ campaign that was designed to encourage patients to get dressed each day. This was an evidence-based campaign that used information that spending all day in pyjamas reduces muscle mass, reduces mobility and can result in reduced self-esteem. The information display included details for patients, staff and relatives. For example, it encouraged relatives to promote independence and to bring in clothes for their family member from home.

The team on Lancaster ward had identified a need to improve their awareness and understanding of patients at risk of self-harm or neglect in relation to dementia and included this as an item in their quality improvement tracker.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from April 2017 to October 2017 Mental Capacity Act (MCA) training had been completed by 85% of staff within medicine.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses</td>
<td>541</td>
<td>619</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>89</td>
<td>109</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
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The trust have confirmed that the deprivation of Liberty training is included in the mental capacity act training module within the mandatory training data provided by the trust.

(Source: Routine Provider Information Request (RPIR) Training)

Patients undergoing procedures in the cath lab were consented prior to their procedures. We also saw verbal consent being obtained for nursing interventions. During our observations on medical wards we saw staff routinely asked for consent before providing care or treatment and this was also reflected in the observational records we looked at.

Multidisciplinary teams worked together to carry out mental capacity assessments for patients when assessing specialist or broader care needs. For example, occupational therapists, SaLTs and social workers worked together on the stroke unit and on Ashby ward to plan care for patients who had experienced a stroke or acquired brain injury and required complex care planning. However, it was not evident there was consistency in the use of mental capacity assessment by nurses on wards. For example, one patient on Carlton Coleby ward was noted to not have mental capacity as a result of an assessment. However, staff could not locate the assessment and the nurse responsible for the patient said they did not know if they had capacity.

Staff completed an incident report where they believed a patient would benefit from a deprivation of Liberty Safeguards (DoLS) authorisation to protect them from avoidable harm. For example, if staff noted a person was confused or wanted to go home despite significant medical needs and the patient did not have mental capacity, they completed an incident report followed by an urgent DoLS application. This helped each ward team to ensure staff understood the purpose of DoLS and were applying it appropriately.

The safeguarding team had carried out Mental Capacity Act (MCA) (2005) and DoLS training for all staff after feedback ward nurses often found this process to be complex. Following this training nurses were able to carry out mental capacity assessments with support from senior nurses. The senior nurse on Burton ward had carried out supervision sessions with staff nurses in completing a DoLS authorisation and stored a sample form on the electronic policy drive. This empowered nurses to be able to carry out an application under specific circumstances and ensured they were confident in the process.

During our inspection we observed nurses on Ashby ward demonstrate effective strategies to care for patients with a DoLS authorisation who were anxious or made efforts to leave the ward. For example, staff were vigilant without making patients feel trapped and when one patient repeatedly approached an exit door staff gently and calmed guided them back to the main area.
Mental capacity assessments were complete and up to date in 29 of the 36 patient records we looked at.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

From December 2016 to November 2017 the Friends and Family Test response rate for medicine at the trust was 28% which was better than the England average of 25%.

- Lincoln County Hospital: 28% (2,677 responses)

The friends and family test percentage recommended by ward for medicine at the trust is shown in the table below:

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(Source: NHS England Friends and Family Test)

In the 2017 national patient-led assessment of the care environment (PLACE), inpatient medical wards scored 82% in the assessment for privacy, dignity and wellbeing. This was a slight improvement from the 2016 PLACE score of 77%.

Patients spoke positively of the ability of staff to provide care with privacy and dignity. For example, one patient on Carlton Coleby ward said, “I’ve appreciated how the nurses are always so careful with my privacy when setting up IV drips or getting me to take my pills. This makes me feel safe but even more important it makes me feel like they respect me.”

Relatives we spoke with on Ashby ward said staff had put up happy birthday banners for their family member and that this demonstrated their dedication to care and compassion.
We observed staff took quick action to address issues that compromised patient dignity. For example, on Ashby ward a nurse noticed a patient walking with the back of their gown open and a pad visible. They discreetly and gently redirected the patient to help them adjust their gown. Although this demonstrated a caring response from the nurse, the ward had no spare clothes or dressing gowns and so staff were limited in their ability to resolve the situation.

One patient on Ashby ward said, “The staff are wonderful, all of them. No grumpy consultants, just wonderful ones!” One patient in the Ingham suite said, “Everyone here is fab. You couldn’t ask for more.”

Some wards displayed dignity in care pledges in public areas to establish the standards of dignified care patients and visitors could expect.

The trust operated a carer’s scheme that enabled carers to access more affordable parking, open visiting hours and subsidised hospital food. This was designed to reduce the pressure on carers during a time of stress.

On one day of our inspection we noted all of the patients in one bed bay on Lancaster ward were in their night clothes in the afternoon. We asked a nurse about this who said each patient had been given the choice and wanted to stay in their night clothes.

We observed therapists delivering compassionate and kind care throughout our inspection. For example, we saw an occupational therapist on Lancaster ward working with a patient who was resistant to improving their mobility. The therapist worked patiently and gently with them, explaining how the therapy would help improve their independence once they were discharged. This had a positive effect and the patient became more motivated to engage in their rehabilitation programme.

**Emotional support**

A team of Macmillan nurses provided emotional support and symptom control for patients cared for in the oncology and chemotherapy services.

Relatives we spoke with on Ashby ward recognised that staff understood their emotional needs and those of patients. For example, when one patient had spoken for the first time on the ward a family member told us, “The nurses were so enthusiastic and passionate and excited when they heard [patient] speak! They recognise how important small steps are and that’s been very clear the whole time we’ve been here.”

Although we observed staff overall provide appropriate and proactive emotional support, short staffing and demands on the service meant this was not always possible. For example, one patient on Ashby ward had a diagnosed psychological condition that required close monitoring and support from staff. They told us they had asked to be able to talk about the condition and how it made them feel with a nurse or doctor but had been told they were too busy to do so.

During all of our observations we saw staff spoke gently to patients and recognised when medical or clinical information might cause distress. For example, a doctor told a patient who had some confusion on Ashby ward that they needed to take a blood sample. This alarmed the patient and the doctor took the time to reassure them and explain what it was for.

Staff on Burton ward had undertaken additional training to provide care for patients living with dementia or significant mental health needs. This meant they were able to provide more compassionate care that included emotional needs and reduced anxiety and stress. For example, where a patient’s condition caused them to wander on the ward staff facilitated this safely by accompanying them and/or ensuring the environment was free from hazards. This helped to
ensure patient’s emotional state remained calm but reducing the need to interfere in an activity that decreased anxiety.

Psychologist support for patients with complex care needs was limited due to long-term sickness and senior nurses told us as the trust had not filled this post with temporary staff, they felt an important element of care had been lost.

During our observations of nurse handovers on Burton ward and Lancaster ward we observed examples of how ward teams ensure patients have emotional support. For example, on Lancaster ward one nurse noted a patient had been frightened and distressed overnight and told the team handing over that talking to the patient at eye level and offering a cuddle had worked well in reassuring them.

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

The trust was developing a new bereavement survey that would more closely establish the needs of relatives and enable a more comprehensive end of life care service to be established. This was part of a range of improvements to establish bereavement services in line with national programmes and pathways.

Results from the 2017 audit of compliance with national standards for venous thromboembolism (VTE) screening found that only 40% of patients were given information about the condition and risk on discharge. Although staff stated all patients were given this information the percentage related to patients for whom there was documented evidence.

The speech and language therapy team met with patients who were due to be discharged and had been cared for under a ‘nil by mouth’ protocol to ensure they understood their care planning in relation to diet.

During our observations on the Ingham suite we saw staff spoke to patients through the process of setting up intravenous medicine. For example, they told each patient what the medicine was for and what it would do and offered them the opportunity to ask questions.

Receptionists in the Ingham suite prepared information packs for patients, which the clinical team issued to them during treatment. This helped patients to understand their condition and treatment in more detail and in their own time when they could absorb the information. We saw these information packs being given and discussed with patients.

Eight out of the nine patients we spoke with on Carlton Coleby ward said they were happy with how clinical staff involved them in their care. For example, one patient said they had been treated elsewhere with a tracheostomy and this was the first team to have given them a tracheostomy care chart to help them improve their self-care. One patient said they had been admitted eight days previously but had not received any information about why they were there. Patients also told us staff had involved them in discharge planning and they felt they had a good understanding of the next stage in this process. Also on this ward we observed staff explain a procedure to a patient in lay terms and then check they had understood it. The patient told us they had been worrying about a procedure because they didn’t understand it and that the nurse’s explanation made them feel much better.

We observed nurses on Waddington ward assisting two patients to mobilise who were at risk of falls. In both cases nurses used clear, direct and patient language and explained how they were supporting patients in line with their moving and handling risk assessment. We saw this helped patients to understand why staff were asking them to move in certain ways and also motivated them to adhere to guidance that was designed to keep them safe.
Two patients we spoke with on Dixon ward said they found it difficult to communicate questions to staff. For example, one patient told us they were worried because their usual tablet was white but a nurse had given them a yellow tablet instead. They said they asked the nurse about this who dismissed the question and told them it was important to take it. They said, “I took the tablet because I was told to but I was worried the nurse didn’t understand the question.” Two relatives on Dixon ward said they had raised concerns with the nurse in charge when they found an elderly patient was due to be discharged home without an appropriate package of care. Their concern was that the patient did not have mental capacity to look after themselves but staff disputed this. They told us it had been challenging to speak with a member of staff who understood their worries about the discharge, which were based on the fact they had been admitted due to self-neglect at home.

Although wards had structured visiting times, each team was flexible around this if it meant relatives could be more involved in care. For example, on Lancaster ward the team facilitated overnight stays by relatives who had travelled internationally to be with a patient and provided access to the pantry for snacks and drinks and comfy chairs to help them sleep.

During a nurse handover on Lancaster ward staff demonstrated excellent levels of understanding of patients there. For example, staff understood that one patient who had been cared for on the ward previously lived in a residential home and had reviewed their care plan to better understand their needs whilst in hospital. In another instance staff handing over let the next shift know that a patient preferred to be called a different name than their legal name as a result of dementia.

### Is the service responsive?

#### Service delivery to meet the needs of local people

**Average length of stay**

**Trust Level**

From October 2016 to September 2017 the average length of stay for medical elective patients at the trust was 3.2 days, which is lower than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 6.4 days, which is lower than the England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical oncology (previously radiotherapy) is lower than the England average. It was also lower for cardiology and clinical haematology.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in cardiology and for geriatric medicine were both higher than the England average.
Lincoln County Hospital

From October 2016 to September 2017 the average length of stay for medical elective patients at Lincoln County Hospital was 3.6 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 6.8 days, which is higher than England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients was lower than the England average in clinical oncology (Previously Radiotherapy), in cardiology and in clinical haematology.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients was higher than the England average for the general medicine as well as cardiology and respiratory medicine.
Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

The trust had significantly improved resources for care of the elderly services since our last inspection. This included the recruitment of clinical nurse specialists in frailty, increased consultant cover and new frailty pathway.

As part of a new trust vision for the stroke service, a team of stroke practitioners were in post and additional funding had been secured for additional junior doctor cover. During a period of weather disruption this service demonstrated continued patient care as doctors used telemedicine to thrombolise patients.

Chemotherapy was made up and sent from Pilgrim Hospital and staff in the Ingham suite told us this was regularly delayed due to a lack of capacity in the pharmacy team. However, both teams were working to reduce delays by using video communication technology to communicate more quickly and by more responsive use of electronic prescriptions.

The chemotherapy services team operated a mobile unit to enable patients in rural areas of the county to access treatment without the need to travel long distances. The mobile unit was equipped with the same equipment as the hospital unit and included full IT access for staff.

Waddington ward, which provided haematology-oncology services, had a lead-lined side room for patients whose treatment resulted in a radioactive state.

Another NHS trust provided an inpatient dialysis service for patients at this hospital. This unit was adjacent to Burton ward and although it was staffed separately, the clinical team on the ward liaised with dialysis staff to provide support when needed.

The frailty admissions unit (FAU) was dedicated to providing specialist care to elderly patients with reduced mobility. A care of the elderly consultant, a frailty nurse specialist and two senior staff nurses provided this service. Staff on inpatient elderly care wards said the FAU reduced pressure on them and meant patients were in a much more stable condition when they were admitted.

The local population was diverse and reflected a range of different languages. Although information in the hospital was not readily available in other languages, all staff had access to an interpreting service and to telephone language support. In addition, a notice on Lancaster ward explained that patients or visitors could request specific printed information in a range of languages. The notice itself was translated into the most common local languages.

Meeting people’s individual needs

A dedicated team of volunteers provided individual support for patients on wards. This team were competency-assessed using a structured checklist and had supervision from a placement
manager. This ensured they could deliver support to patients within established boundaries and with a good understanding of health and safety policies and principles.

In the 2017 national patient-led assessment of the care environment (PLACE), inpatient medical wards scored 62% for the dementia-friendly environment and 76% for adaptations for patients with a disability. Both scores were similar to the overall hospital averages in these measures and both reflected improvements in both measures from the 2016 PLACE results, from 50% for dementia criteria and 65% for disability criteria.

Nursing staff had the opportunity to take on ‘link’ roles, which enabled them to specialise in specific areas of care and treatment. This involved undertaking more advanced training in the subject with clinical nurse specialists and delivering learning and training to colleagues on their ward. Link staff, who could be nurses, HCAs or assistant practitioners (APs), also prepared information displays on their wards to provide colleagues with access to facts about conditions and to guidance on care and treatment. For example, an AP on Burton ward was the link for tissue viability and managed wound dressings and pressure care. Staff spoke highly of the additional capacity and expertise this individual provided, including a liaison role with the tissue viability team. We looked at information displays prepared by link staff in each clinical area and found an overall high standard of work. For example, on Lancaster ward the link staff for sepsis had prepared an excellent, up to date information display for colleagues and patients on the signs, symptoms and risks of the condition.

The senior team on Burton ward had established a programme of ambassador roles as part of a project to improve staff morale and motivation and to improve the outcomes of patients with highly complex needs. There were 16 specialty ambassador roles in place including for diligence, diabetes, safeguarding, palliative care and nutrition. Each ambassador maintained their own resources folder with evidence of development and information that would help them deliver improved services in their specialist area.

Patients in the complex care service often needed one-to-one nursing care due to the acuity of their condition. We saw staff had to prioritise patients with the greatest level of need because there were not always enough staff to provide individual care at all times. On Burton ward we saw a patient who was medically fit for discharge but awaiting a community placement and staff had maintained continual one-to-one care due to additional risks associated with a learning difficulty.

Nurses, APs and HCAs used rounding observation charts to monitor each patient in addition to their clinical treatment and ensure their individual needs were met. We looked at the charts for each patient in the stroke unit on one day of our inspection and found staff completed and documented observations consistently every two hours. We found variable standards of completion on Lancaster ward, including for one patient that required hourly rounding but there was an eight-hour gap in recording. On Dixon ward, staff had not always noted how often rounding should be completed and documentation was sporadic where the frequency was noted. For example, one patient should have had two-hourly rounding but there were gaps in this of up to five hours.

Five patients we spoke with on Carlton Coleby ward said staff had met their individual needs. Three patients said they observed staff to be very busy but had never had to wait more than a few seconds for someone to respond to their call bell.

Although most patients we spoke with were positive about the ability of the various hospital teams to meet their needs, it was not always evident non-clinical services were able to adapt to specific needs. For example, one patient on Carlton Coleby ward missed a meal due to undergoing a diagnostic scan. They were disappointed the catering team could not keep their meal or serve it...
later and the ward team were unable to provide a soft meal for them, which had been noted as a requirement by the speech and language therapy team. The patient told us this meant they went hungry for the night and had to wait until breakfast to eat. In another instance a patient on Dixon ward missed lunch because they were undergoing a scan. When they returned staff had not saved lunch for them and they were only offered tea and biscuits instead.

One patient on Lancaster ward said they had been an inpatient long enough to develop a daily routine but had not left the bed bay. They told us they had heard there was a day room somewhere on the ward but wasn’t sure where it was or if they were able to use it.

Staff did not always have the resources or time capacity to improve communication with patients who were not able to do so verbally. For example, one patient on Lancaster ward found it challenging to communicate due to slurred speech and needed additional time to do so. We observed staff providing good care but not interacting with them. We asked the patient about this who told us they felt staff were too busy to spend time having a conversation. During the lunch service on this ward we observed a patient who was reluctant to eat their meal. The member of staff supporting them said they had no tools to help them communicate and so did not know what the problem was. However, this ward had a communications assistance folder that included communication cards in pictorial format and we were unable to establish why staff did not use it.

Lancaster ward had a day room for use by patients but this was used in part for storage. Although it had a television, a library area, a dining table and easy chairs, we found it was also used to store bagged soiled mattresses and equipment awaiting collection. There was a reminiscence area in the day room but this was partially blocked by equipment and a dementia information display was inaccessible due to equipment blocking access.

Burton and Scampton wards had been refurbished to provide adapted environments for patients living with dementia. This included organising beds into smaller bays and colour-coding each bay and other communal areas to help patients recognise them. Scampton ward had been fitted with lighting designed to facilitate a calm environment and to reduce glare for patients with dementia, which could increase disorientation. In addition, there was no central nursing station in the patient area of this ward. This was a strategy to reduce the clinical feel of the ward and instead each bed bay had a desk for clinicians. This enabled them to complete their work whilst remaining more visible, and therefore consistent, to patients. A well-equipped day room was available on this ward but its location, between two sets of secure doors, meant patients could not use it without staff supervision. This reduced accessibility as pressures on the staff team meant they were rarely able to spend time in the day room with patients.

Inpatient wards maintained a stock of personal items for patients to use such as socks, razors and toiletries.

There was limited provision or staff to obtain specialist support where patients were admitted with needs relating to drug and alcohol use. For example, two patients had been cared for on Burton with complex needs relating to drug addiction and staff did not have access to a drug and alcohol liaison team. They said care had been consultant-led and they would call the mental health crisis team if they felt unable to meet individual needs.

Staff on Burton and Lancaster wards had developed ‘grab packs’ to assist in providing care in specific circumstances. For example, if a patient experienced a fall, the falls grab pack contained pre-printed sets of documentation that staff needed to complete include a copy of the care pathway. Similar packs were available for the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) and included application forms for urgent DoLS and an example of a correctly completed application form. A discharge grab pack included templates of the forms staff
needed to complete as well as the checklist to ensure appropriate support and follow-up care had been arranged or explained.

A team of volunteers worked across all wards and provided recreational activities on a one-to-one basis. On care of the elderly wards the volunteers worked to reduce the risk of social isolation amongst patients and spent time in conversation with them about current affairs, their personal lives or in reminiscence.

The FAU and Burton ward provided ‘twiddle muffs’ for patients living with dementia. Twiddle muffs are fabric sensory bands that enabled patients to occupy their fingers and therefore reduce tension and stress through distraction. In addition, both wards had a digital television system that enabled staff to tailor specific reminiscence material to each patient, such as to a specific period in their life. This was a mobile system that could be used in individual bed spaces.

An enhanced care package had been introduced in wards that provided care for patients with complex needs. This included a five-day scoping tool that enabled staff to establish each patient’s baseline mental health to establish if they were at risk of delirium and whether they would benefit from a DoLS authorisation.

**Access and flow**

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

Trust’s referral to treatment time (RTT) for admitted pathways for medicine has been similar to the England average for the whole-time period between November 2016 and October 2017.

In October 2017 (and November 2017) the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.

From November 2016 to September 2017 the trust showed an average of 75% versus the England average of 90%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were below the England average for admitted RTT (percentage within 18 weeks).

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<th>Result</th>
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(Source: NHS England)

Following our inspection, the trust told us the Neurology Service had achieved 96.35% for RTT (April 2018 data). The Neurology Service went through a period of planned temporary closure due to demand significantly exceeding capacity. There was an agreed recovery plan in place supported by Local CCG’s. The specialty had reduced new patient waits from 30 weeks in July 2016 down to 2 weeks in April 2018. Patients waiting for a review appointment had reduced from a total of 952 patients overdue an appointment with a wait of around 40 weeks, down to 161 patients waiting around 20 weeks.

APs assisted with discharge planning, including ensuring an appropriate package of care was in place.

The acute oncology service (AOS) meant patients could access the service in a number of ways, including a 24-hour triage service. The chemotherapy day service offered drop-in sessions as well as pre-booked appointments. This meant if patients who were receiving chemotherapy felt unwell they could attend the service and be triaged for additional review and treatment. Staff told us this was a popular service and meant patients always had access to specialist care during treatment that could be traumatic. Patients could also access this service by phone and a shift coordinator ensured they attended the service in person if the phone triage indicated concern. Although the flexibility of services meant patients had more options to access urgent care, it meant pre-booked appointments often ran with significant delays. The AOS team also reviewed oncology patients treated as outliers in other clinical areas.

Patients with complex needs often needed the support of social workers to implement appropriate discharge plans and staff described their availability as sporadic. This meant patients often stayed on wards for significant periods of time despite being medically fit for discharge.

There had been a significant improvement in waiting times for cardiology patients between June 2017 and March 2018. At the beginning of this period there was an average 27 week wait for a first appointment with 701 patients waiting. In addition, 811 follow-up appointments were overdue with an average 33 week wait. At the end of this period the average wait for both appointments was 10 weeks. The service achieved this using a recovery plan that introduced additional consultant-led clinics, virtual clinics and improved slot management.

A discharge coordinator was based on Lancaster ward and supported the clinical team in preparing plans for patients with complex needs.

Patient moves per admission

The trust said within their routine provider information request that they “currently do not collate reason for patient moves so unable to supply this data”.

Evidence appendix United Lincolnshire Hospitals NHS Trust
The trust were able to report how many times a patient had a ward move between 22:00 and 08:00am by ward between November 2016 and October 2017. During this period

- Lincoln County Hospital had 8,963 (746 a month)

(Source: Routine Provider Information Request (RPIR) – P52 Bed moves at night tab)

Learning from complaints and concerns

Summary of complaints

From October 2016 to September 2017 there were 188 complaints about medical care from a total of 750. The trust took an average of 75 days to investigate and close; this is not in line with their complaints policy, which states complaints should be completed within 35 days (80% of them) and complex complaints should be responded to within 50 days. However; there had been improvement in response times and the quality of responses since our last inspection.

The top three categories reported for medicine were communication with patient (21) followed by communication with relative/carer (18) and 15 associated to delay or failure to diagnose (including e.g. missed fracture).

There are 41 complaints within medicine that were put against individual subjects, of these at least nine were associated to communication between staff and patients and their families, as well as 16 related to delay and failure around observations, record keeping and waiting times.

General medicine had the most complaints reported against a specialty with 39, followed by oncology with 30 and 25 against cardiology. 32 complaints were reopened of which none have been reclosed.

- Lincoln County Hospital: There were 101 complaints, communication with relatives/carers as well as communication with patients were the two most complained about subjects with 11 and 10 complaints received.

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

The nurse in charge of each ward displayed the number of complaints and compliments they had received for each month on the safety and quality information board visible to everyone who visited. This helped to indicate the performance of the ward from the point of view of patients and their relatives. For example, in February 2018 Lancaster ward received one complaint and 13 compliments.

Is the service well-led?

Leadership

Specialist and acute medical services were organised into four clinical directorates within the integrated medicine business unit. Each clinical directorate had a triumvirate leadership team with a clinical director, general manager and a head of nursing. Directorate teams included a nurse consultant, matron, business manager, up to three heads of service and six other managers and support officers.

All of the ward and clinical staff we asked spoke positively about local leadership and said their band six and band seven senior nurse teams were accessible and supportive. They also said
matrons were easy to reach and very supportive particularly those who were willing to help clinically.

The matron for haematology, oncology and chemotherapy worked on a trust-wide basis and matrons for other specialties were based at this site permanently.

Senior nurses on wards told us they felt much more respected by the senior trust team to run their own wards within improved governance structures.

As part of the trust’s improvement plan, the matron team had introduced a daily ‘golden hour’. This was protected time ring-fenced for each matron to carry out leadership duties. This was an improvement as historically matrons lost dedicated leadership time due to bed management duties and the requirement to attend meetings., however matrons still felt they had little time for quality improvement as a result of being drawn into operational pressures, particularly over the winter period.

Band seven nurses told us they felt well supported by their senior teams and new band seven nurses said they had been supported by more experienced colleagues. They described this group of staff as a good support network and said although the new role was challenging they had never felt isolated in it.

**Vision and strategy**

The trust had a five-year vision to achieve an improvement in standards across five key areas by 2021. As part of this each ward had a large format poster display that the team used to display their top three improvements and top three goals that were in the context of the 2021 vision. The chart had a space for a daily topic or target for staff that was discussed during morning safety briefings, handovers or huddles. The senior ward nurse updated this as the team progressed towards their goals. For example, on Carlton Coleby ward the senior nurse had displayed an achievement that a new working culture had been facilitated that enabled staff to get immediate feedback on improvements in their work. The team on Lancaster ward had identified their top three improvements in core learning completion, ward cleanliness and the completion of appraisals.

The trust had an overarching people strategy that, alongside the Lincolnshire sustainability and transformation plan, aimed to facilitate the development and improvement of clinical services. The trust incorporated staffing measures such as sickness and vacancy rates and incorporated a need for significantly improved staff morale as a key measure of success. Four core measures of the plan directly involved staff in wards and departments with substantive focus on identifying and developing talent. During previous inspections we found staff had limited opportunities to progress and there was a pervasive feeling of apathy amongst many clinical teams. The trust acknowledged this and had structured the new strategy to engage staff and encourage a culture of enthusiasm that contributed to a sustainable service. The senior trust team had established a staff charter to support the people strategy with behavioural standards and a support structure to help staff develop their skills and role.

Each ward team had developed a philosophy of care. This was displayed in their ward and outlined how they strived to provide care and the key areas of importance for them. For example, the philosophy of care on Lancaster ward was based on dignified, person-centred care that involved both the patient and their relatives. The team on Burton ward included the goal to provide care within a warm and friendly environment as a key element of their philosophy.
Culture

There was a culture of transparency in the hospital, demonstrated through ‘time to talk’ boards in place in each ward. This clearly outlined the operational status of the ward each day, including challenges relating to staffing, multidisciplinary team availability and issues with the environment or equipment. This enabled any member of the wider hospital team to see, as a snapshot, the status of the ward and pressures.

All of the staff we spoke with described excellent working relationships in their clinical area. For example, one member of staff on Burton ward said, “There’s a great deal of respect here between everyone. The consultants respect the nurses and so on. Everyone is open to challenge and discharge regardless of their role – this is really important.” A student nurse on Lancaster ward told us they were planning their future career around the hospital because of the welcome and support they had received.

Staff we spoke with in the endoscopy unit were demonstrably passionate about their work and spoke positively about developing plans to enable them to carry out ERCPs in the department. This would reduce the need to transport equipment between endoscopy and radiology. Staff in the Ingham suite were similarly enthusiastic and said they felt the contact time with patients was very rewarding. The senior nurse on Burton ward said they were very proud of the transformation of the ward from a demoralised unit to a service in which staff were passionate and motivated. They told us the ward refurbishment alongside the improvements implemented by the trust had resulted in positive momentum amongst staff.

Ward staff spoke positively of communication within their teams and with their senior colleagues. Staff on some wards had established secure, restricted-access social media communication groups to enable them to stay up to date with changes and new policies. This meant staff could stay up to date even if they could not attend staff meetings.

Governance

The senior divisional team described the clinical governance system as starting at ward level. This meant governance issues and assurance were connected directly to divisional-level governance structures, which were overseen by heads of service. Clinical cabinets for nursing and governance maintained oversight of governance outcomes and the triumvirate leadership teams reported into patient safety committees. Each cabinet team attended a monthly operations meeting and clinicians and matrons attended monthly meetings for job planning. Each medical specialty held their own governance meetings and the clinical director joined them as needed to provide oversight of the assurance process.

Divisional teams and senior clinicians used a series of clinical governance meetings to review patient outcomes, morbidity and mortality. This included a review of patient deaths, serious incidents and complaints as tools to assess performance. We looked at a sample of meeting minutes from three governance meetings. In each case the meeting was well attended by an appropriate cross-section of staff and there was a tracking system in place to resolve incidents, complaints and other events. Clinicians presented findings from investigations into clinical outcomes and shared these for distribution through patient quality and safety processes.

During our inspection we observed that governance processes in place in the chemotherapy service worked well and contributed to positive patient outcomes. For example, we observed a nurse issue intravenous antibiotics for a patient following a neutropenic sepsis screen using establish patient group directions. The escalation process to the on-call specialist registrar worked well and the doctor attended the day unit to review the patient.
A consultant led a haematology ward meeting twice weekly that the team used as a governance process for oversight of daily consultant ward rounds and three times weekly reviews of medical outliers.

There was a lack of governance in place for the walk-in aspect of the chemotherapy service. This was because there was no risk assessment in place for the impact the service had on booked appointments for established staffing levels. As the demand on the service was unpredictable on a daily basis staff were unable to plan resources for it. In addition, there was no standard operating procedure in place for the service, which meant the nurse in charge and nurse coordinator were required to continually adapt the service as each shift progressed.

**Management of risk, issues and performance**

It was not evident from looking at incident reports that clinical staff had appropriate training or understanding of policies to follow in the event of an aggressive or violent patient. For example, in September 2017 a nurse left their inpatient ward to support a vulnerable patient and was assaulted in the process. Other ward staff failed to act and did not call security or take other appropriate action. This placed the nurse at significant personal risk and although the result of the investigation indicated staff would receive clearer instructions in such situations, it demonstrated a need for improved security awareness by ward staff. Several other incidents were reported in medical areas where staff were attacked or assaulted. Although the investigation for most incidents noted whether or not staff involved needed time off, there was limited evidence of overall learning that addressed repeated instances of significant levels of violence and injury to staff.

Each ward had a safety and quality dashboard that was used to monitor risk, performance and quality. This included an overview of contributing factors such as incidents and accidents as well as data from the NHS Safety Thermometer. The dashboard provided an overall score and enabled ward teams to quickly identify where they needed to focus improvements and where they were achieving a high standard.

Senior divisional staff used a risk register to assess the severity of risks to the service and to measure and track control measures in place. As of February 2018, medical care services at Lincoln County Hospital had 31 live risks on the risk register. We reviewed all of the risks and found variable standards and frequency of review. For example, in October 2016 it was identified that the environment in the Ingham suite was no longer fit for purpose due to demands on the service. Although there was evidence of discussions with the trust finance and estates teams this was repeatedly chased and as of February 2018 there was no established plan in place. A risk had been identified in clinical haematology that the lack of 24-hour consultant cover meant patients were not always reviewed within 14 hours of admission by a senior clinician. This risk had been raised in November 2015 and although there was evidence of progress increasing consultant cover, in March 2018 the service had still not resolved the issue. Five risks related to short staffing and three risks related to a lack of capacity in individual services. One staffing risk related to the lack of junior doctors available from the deanery, which had led to a significant number of exception reports from existing junior doctors concerned about their workload and working hours. There was evidence divisional teams identified short-term solutions to staffing issues such as the redeployment of nurses and the use of locum doctors. However, none of the control measures had resulted in long-term change.

A dedicated security team provided cover 24-hours, seven days a week to manage risks to patients, visitor and staff. Overall compliance with mandatory training in the security team was 66%, ranging from 43% to 86% for each member of the team. Security officers were required to undertake training in conflict resolution, customer service, and safeguarding and risk awareness amongst other clinical areas such as resuscitation and infection control.
Ward staff submitted an incident report in June 2017 regarding allegations that a security officer was excessively aggressive with a patient. This was resolved in November 2017 following a disciplinary process. Ward staff submitted another report in June 2017 regarding the rough handling of a patient by the security team and inappropriate verbal aggression that escalated a tense situation. The incident log noted this had been resolved but there was no documented outcome or learning.

Twelve members of ward staff we spoke with told us they regularly worried about their safety or the safety of their patients due to security issues. One member of senior staff said there had been a charge of shift in the security team during an incident, which meant the officer had left the ward whilst the police were in attendance. They said the security officer had not handed over to their next shift and so no further security support came to the ward. They said this had been followed up by the police and demonstrated a lack of understanding of patient and staff needs in the clinical environment. Three members of staff said they would not call for security support unless they felt they were under “serious threat” because previous incidents indicated to them that the security team were not resourced to de-escalate situations. Other concerns were raised with us during our inspection about the approach and skills of the security team and we raised these with a divisional leadership team.

Senior nurses described the management of risk relating to a shortage of nurses as poor. This related to a new ‘cohort interview’ system the trust had implemented that interviewed and recruited nurses centrally and then deployed them to individual wards. For example, Burton ward had received no new nurses or HCAs for over six months following the implementation of the new recruitment method. A senior nurse on another ward said although they had been allocated new nurses they felt the trust had not matched nurse interests or skills with the ward they had been placed on.

Staff on Lancaster ward had developed a four-part quality strategy to help them achieve the trust’s vision through specific criteria. These were safety, excellence, continuous improvement and a culture change in clinical effectiveness. The strategy included the key risks to the ward, such as sub-optimal staffing levels, and helped the team to identify new ways of working.

As part of the trust’s vision and strategy and improvement programme a wide-ranging ward accreditation scheme had been implemented. A team of quality matrons used a quality assessment for each ward that considered staff knowledge and performance in 13 key areas such as safeguarding, identifying deteriorating patients and end of life care. Wards were awarded a status based on the red, amber, green system and were required to submit an action plan targeting specific improvements. The first wave of accreditation had been completed with five wards at amber status and three wards at red status. Three wards achieved green status for their work in end of life care and one ward each achieved green status for effective workforce and continence management. The second wave of accreditation assessments had started at the time of our inspection and the first available results indicated significant improvement. This was for Shuttleworth ward, which had moved from red status to amber status and had achieved green status for patient flow/discharge and end of life care. All of the staff we spoke with were positive about the accreditation programme and said it had helped them to identify where they needed to improve and to get help in achieving this. This was a substantive programme of work that demonstrated considerable focus on improving patient safety and outcomes.

The violent behaviour of patients on Dixon ward had been entered on the business unit risk register in September 2014. This included increasing instances of patients spitting and assaulting staff, threatening sexual behaviour and destruction of equipment. There was an insufficient response to this risk from the trust and incident records noted staff were increasingly unable to
address the risk with inconsistent support from the security team. In February 2018 an update was recorded that noted patients with a risk of violence were accommodated across the hospital rather than concentrated on Dixon ward. The implementation of a ‘break out’ area in the unit, which would provide space for patients to deescalate their behaviour, had not been approved by the trust.

**Information management**

We found patient notes were stored in open-access trollies at the entrance to bed bays on wards or adjacent to nurse stations. On Carlton Coleby ward notes trollies were stored in a lockable cupboard. However due to the amount of storage in the room the door could not be closed or locked. In the Ingham suite, confidential staff training files were stored in an unlocked cupboard in an unlocked storage room. In all other areas trollies were stored unsecured by nurse stations or at the end of bed bays. During visiting hours there was a significant risk unauthorised people could gain access to confidential information, particularly in very busy wards that were short of staff. On Ashby ward we found loose-leaf notes had been left on top of notes trollies without being filed away, which meant they were easily accessible.

**Engagement**

The trust had undertaken a six-month period of engagement with staff to build understanding of the 2021 strategy and transformation plan. This identified broad support for the overall programme with 98% of staff agreeing that the trust’s services needed to change. Engagement indicated the trust needed to increase the confidence of staff teams in the transformation vision as only 41% of staff said they believed the trust could succeed in transformation. Key feedback from staff included a need to introduce a rehabilitation ward at each hospital and move services for the management of patients with long term conditions into the community. The trust planned to hold a large-scale launch event for the strategy that would include how they planned to address staff suggestions, concerns and feedback.

A patient experience committee maintained oversight of service improvements that could be submitted by any ward or clinical department and ensured improvements were based on need and evidence. The patient experience committee was in the process of reviewing a substantial overhaul of end of life care services that included the implementation of a national care programme, improved bereavement services and a two-year collaborative project to establish patient feedback.

Senior nurses described an improvement in engagement in the previous three years. For example, the director of nursing held a weekly band seven nurse meeting to improve communication and to enable each nurse the opportunity to provide feedback. We asked senior nurses about this and in all cases, we received positive feedback. One nurse said, “This is a really good forum to be able to discuss things honestly.”

Each ward displayed a ‘You said, we did’ information board that staff used to indicate the actions they’d taken as a result of feedback. For example, on Lancaster ward patients had noted the noise from the closing of bin lids was disturbing overnight. As a result, the team had provided soft-closing bin lids.

Staff we spoke with in several areas demonstrated a long-term commitment to the trust, which was acknowledged through long service awards and recognition. For example, during our inspection one HCA had been recognised in an award for 28 years of service and in another example the chief executive officer had visited a ward to congratulate a nurse on their long service. We spoke with an administration assistant in the chemotherapy service who had worked with the trust for 18 years and described their role as rewarding. Although the length of service and loyalty of many
staff was highly commendable, staff also spoke with us about their workloads and pressure on the service. One senior nurse said, “We teeter sometimes. We’re doing less than our best because we are so short staffed and we have lost so many highly skilled staff who can’t work with the pressure anymore. We’re doing the bare minimum to keep going, to keep people alive and that’s it. Can we keep going?”

During January and February, the Medical triumvirate leadership team had carried out 4 engagement visits to ward areas; Burton, Scampton, Navenby & Carlton Coleby. This formed part of a series of visits to wards during 2018. The aim of these visits was to engage at ward level with staff to share with them the vision for the directorate and how this tied in to the wider trust strategy. It was also designed to be an opportunity for ward staff to have some protected time to access the management team to raise with them any questions or concerns that they had. The team aimed to provide opportunities for “quick fixes” that would help ward staff in their work without the need for lengthy processes. Each Ward had received a photographic poster with pictures of the management team and the date and purpose of the visit prior to their visit. These posters were displayed on the ward noticeboards at the time our visit. Staff also received a monthly newsletter from the triumvirate leadership team which informed them of the discussions that had taken place at their monthly clinical cabinet team meeting and shared with staff key pieces of work or planned changes within the medical areas. At our last inspection we found there were gaps in the visibility and accessibility of the senior team and engagement exercises aimed to improve this. However, during conversations with ward staff, we found the majority of nurses and HCAs could not name any member of their divisional leadership team and said they had never met them.

Posters were displayed in wards to explain to patients and relatives why they would see staff using handheld devices. It explained these were clinical observation devices and not personal mobile phones.

The trust had issued mandatory staff meeting and communication requirements to each ward team as a strategy to ensure all staff were well informed as to improvement work and progress of action plans. Each ward was able to approach this in the most appropriate way for them. For example, some wards scheduled a rotation of staff meetings and others introduced daily ‘10 at 10’ briefings. A member of staff on Dixon ward published the ‘Dixon Eye’ newsletter, which they distributed to everyone on the ward.

Learning, continuous improvement and innovation

Audit plans indicated a continual drive to identify opportunities for improvement and innovation in care and treatment. For example, an occupational therapy audit planned for 2018 would review how patients experienced visual changes following a stroke and a physiotherapy audit was reviewing a substantial number of referrals to identify how inappropriate referrals could be reduced in future. The dietetics team audit programme focused on patient outcomes and included an audit of specific diet textures and improving the management of oncology referrals.

Healthcare assistants were offered the opportunity to progress to assistant practitioner posts and the trust sponsored them to complete the associated degree. This reflected an overall drive by the trust to improve investment in professional development opportunities for staff. For example, one member of staff had completed an MSc in frailty and two others were undertaking MSc-level study.

Staff in the chemotherapy service were not assured of the sustainability of the service due to increasing demand. For example, the walk-in triage service was under increasing pressure and staff told us this meant appointments frequently ran late. In addition, the service was not equipped to provide immediate care for sick patients and staff therefore spent significant time referring
patients to the inpatient service. The chemotherapy day service shared a waiting room with other services, which had an impact on patient experience as the area could become crowded. Staff were clear they did not feel this had ever affected patient safety but did feel they had outgrown the comfortable use of the unit. We spoke with the service matron about this who told us a task and finish group had been established to identify how to address the issue. The group was considering an expansion into adjacent space to increase capacity and this was a priority as the waiting room was sometimes so busy patients had to stand.

The acute oncology service planned to introduce an ambulatory assessment area in Waddington ward that would enable patients who presented in the emergency department to be transferred immediately for specialist assessment. The senior team had prepared a business case for this and had visited a similar service in another trust to strategize how to implement the most effective changes to meet patient need.

At our last inspection we found significant concerns relating to patient safety and outcomes on Navenby ward, particularly in relation to the care of patients with diabetes. At this inspection we found a range of substantial improvements had been implemented and there was a demonstrable drive by the ward team and by the divisional leadership team to redesign the ward structure. An action plan was in place that had resulted in a more senior nursing presence on the ward, increased matron presence, improved staff competencies and new assurance standards for patients diagnosed with diabetic ketoacidosis. A significant element of the action plan had been to improve staff engagement. This included monthly focus groups, the use of ‘positivity jars’ to encourage staff to identify highlights of their day and pass on compliments and a new matron communication system.

**Surgery**

**Facts and data about this service**

The surgical unit at Lincoln County Hospital (LCH) has 179 inpatient beds across six surgical ward areas and 16-day care beds on the Surgical Assessment Lounge. At LCH there are 11 theatres, two of which are laminar flow (this is a type of air conditioning that reduces air borne infections) including theatres for day case surgery. One theatre is available for emergency surgery 24 hours a day, seven days a week.

Details of the surgical wards are shown below:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Specialties provided</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Branston</td>
<td>Gynaecology</td>
<td>18</td>
</tr>
<tr>
<td>Clayton</td>
<td>Urology</td>
<td>27</td>
</tr>
<tr>
<td>Greetwell</td>
<td>General surgery</td>
<td>28</td>
</tr>
<tr>
<td>Hatton</td>
<td>General surgery</td>
<td>22</td>
</tr>
<tr>
<td>Neustadt-Welton</td>
<td>Orthopaedics</td>
<td>28</td>
</tr>
<tr>
<td>Shuttleworth</td>
<td>Trauma</td>
<td>28</td>
</tr>
<tr>
<td>Surgical Emergency Admission Unit (SEAU)</td>
<td>General surgery</td>
<td>28</td>
</tr>
</tbody>
</table>
From August 2016 to July 2017 the trust had 46,974 surgical admissions. Emergency admissions accounted for 13,731 (29.2%), 26,231 (55.8%) were day case and the remaining 7,021 (14.9%) were elective.

(Source: Hospital Episode Statistics)

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

**Mandatory training completion rates**

The trust set a target of 90% for completion of the majority of mandatory training, however some modules had a higher target which can be seen in the table below.

A breakdown of compliance for mandatory training courses from April 2017 to October 2017 for medical/dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>102</td>
<td>109</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>100</td>
<td>109</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>99</td>
<td>109</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>97</td>
<td>109</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>96</td>
<td>109</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>92</td>
<td>109</td>
<td>84%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>92</td>
<td>109</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>91</td>
<td>109</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>85</td>
<td>109</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>75</td>
<td>109</td>
<td>69%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>73</td>
<td>109</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>6</td>
<td>0</td>
<td>N/A</td>
<td>TBC</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>5</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The trust’s target was not met for eight modules at Lincoln County Hospital.
A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and health visiting staff in surgery is shown below:

Lincoln County Hospital – Surgical Qualified nursing staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>258</td>
<td>260</td>
<td>99%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>249</td>
<td>260</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>233</td>
<td>260</td>
<td>90%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>228</td>
<td>260</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>227</td>
<td>260</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>226</td>
<td>260</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>220</td>
<td>260</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>217</td>
<td>260</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>204</td>
<td>260</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>194</td>
<td>260</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>184</td>
<td>260</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>98</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>14</td>
<td>0</td>
<td>N/A</td>
<td>TBC</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The trust’s target was not met for nine mandatory training modules at Lincoln County Hospital.

(Source: Routine Provider Information Request (RPIR) – Training)

Mandatory training for all staff groups included; fire safety training, moving and handling, infection prevention, equality and diversity, information governance, health and safety and, basic life support. This was accessed by a mixture of face to face and e-learning modules.

Clinical staff we spoke with were aware of the trust physiological observations and sepsis policy. At the time of our last inspection the trust had no formal sepsis training. Sepsis eLearning for all front line staff had recently introduced via mandatory training along with the introduction of an electronic sepsis screening and sepsis six bundle based around the National Institute for Health and Care Excellence guidelines (NICE), and sepsis trust guidance.

Information received prior to our inspection showed, as at October 2017 that the trust target for mandatory training of qualified nurses in surgical business units was not met for nine mandatory training modules at Lincoln County Hospital. However, during our inspection all ward managers we spoke with were able to provide us with updated data, which indicated that training had continued over the winter. For example we saw training in slips trips and falls on all wards was above the trust 90% target.

The trust target for mandatory training of medical and dental staff was not met for eight modules at Lincoln County Hospital. However, all 18 medical staff we spoke with told us they had accessed mandatory training.

Junior doctors informed us they had dedicated time for completion of mandatory training during their initial foundation year one (FY1 - foundation doctors on a two-year general postgraduate training programme) induction but senior house officers (SHOs), registrars and consultants were required to complete training in their own time. All FY1 and FY2 doctors received basic life support (BLS) and intermediate life support (ILS) training as part of their induction.
Mandatory training was accessed either through an electronic learning tool or, for some subjects, face to face. Nursing and medical staff told us that due to staffing shortages face to face training was sometimes difficult to attend. However, ward managers we spoke with on all of the wards tried to plan training into the electronic roster to ensure the wards were covered and training was attended in a timely manner. Staff said this was better than attending on days off or during annual leave.

Safeguarding

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training from April 2017 to October 2017 for medical/dental staff in surgery is shown below:

Lincoln County Hospital – surgical / dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>97</td>
<td>109</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>97</td>
<td>109</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95</td>
<td>109</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>94</td>
<td>109</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>41</td>
<td>48</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for all safeguarding training modules for which medical and dental staff were eligible at Lincoln County Hospital.

A breakdown of compliance for safeguarding for surgery is shown below:

Lincoln County Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>235</td>
<td>260</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>234</td>
<td>260</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>232</td>
<td>260</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>231</td>
<td>260</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was not met for Safeguarding Adults (Level 2) and Safeguarding Children (Level 2) safeguarding training modules for which qualified nursing and health visiting staff were eligible at Lincoln County Hospital.

(Source: Routine Provider Information Request (RPIR) Training)
The trust had a safeguarding lead at executive level, in addition to local named leads for children and adult safeguarding. All staff we spoke of were aware of the safeguarding leads and staff told us they were readily accessible. Safeguarding link nurses were identified on the ward areas whose aim was to update and support staff with regard to safeguarding processes and information.

In all wards and theatres staff told us they were trained to level two for adults and children and had completed on-line and face to face training. All staff we spoke with were clear about what constituted a safeguarding concern and how to escalate a safeguarding referral. We saw evidence of safeguarding procedures being followed for patients on Clayton and Shuttleworth Wards during our inspection.

Female genital mutilation (FGM) is defined as the partial or total removal of the female external genitalia for non-medical reasons. Nursing and medical staff spoken with confirmed that they had received FGM training which was included as part of mandatory training.

**Cleanliness, infection control and hygiene**

Lincoln County Hospital (LCH) participated in ‘Patient-Led Assessments of the Care Environment’ (PLACE) 2017. PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this trust demonstrated a compliance level of 96%, which was worse than the England average of 98%. However; it was an improvement on the 2016 score of 93%. A trust wide action plan was in place to further improve these scores.

The surgical ward areas, pre-assessment rooms, operating theatres and recovery appeared visibly clean. The trust produced a cleaning handbook, which was available on each ward detailing the schedule of cleaning. However, senior nursing staff on Neustadt-Welton ward did tell us that it was often difficult to maintain cleaning schedules on the ward due to its high number of ensuite facilities. The wards had four bays and 12 side rooms with ensuite facilities. In order to maintain cleaning schedules three housekeepers were allocated to the ward however, with staff shortages in housekeeping they were moved to other wards at least twice a week. As the housekeepers were responsible for food preparation and cleaning this caused difficulties in completing the full cleaning schedule. This was highlighted at our last inspection and remains a problem. Cleaning scores for January indicated an 87% cleaning score for Neustadt-Welton ward below the trust target of 95%.

The trust had guidelines for the management of patients with *Clostridium difficile* (*C. difficile*) Infection and a guideline for the control of Methicillin-Resistant Staphylococcus Aureus (MRSA). Site specific infection prevention surveillance meetings were held monthly.

Trust wide there had been 58 cases of *Clostridium difficile* (*C. difficile*) infections between April 2017 and January 2018 with four cases occurring at this hospital in the surgical areas. *C. difficile* is an infective bacterium that causes diarrhoea, and can make patients very ill.

Meticillin resistant staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections. Between April 2017 and January 2018, there were two cases of MRSA bacteraemia reported at this trust. Patients were screened pre-operatively for MRSA as soon as possible when admitted as an emergency. This was in line with local policy and national guidance.

Meticillin sensitive staphylococcus aureus (MSSA) differs from MRSA due to the degree of antibiotic resistance. Between April 2017 and January 2018 there were 12 recorded cases of MSSA at this trust, of which two occurred within the division of surgery.

It is a mandatory requirement to participate in the Nosocomial Infection National Surveillance Scheme (NINSS) study of Surgical Site Infection (SSI). The trust had reported no surgical site infections for the period April 2016 to March 2017 at LCH. The trust reported surgical site infections for hip and knee replacement surgery, neck of femur repair and reduction of long bone fracture.
In information provided to us, the trust stated they had participated in SSI surveillance for the past 12 months, with a rolling programme for fractured neck of femur and a month rotational programme for total hip replacement and total knee replacement. The data was collated by the nurse specialist for total hip and knee replacements. This data was uploaded to the public health England website. The data was provided to the infection control team via the Divisional reporting system.

The service submitted data to the surgical site infection surveillance service across the trust, and received reports into specialties. For orthopaedics this included every patient who had undergone a neck of femur repair (NoF). The service had a consistently low rate of infection for NoF patients reported, and had completed two audits over the past two years to assure themselves of compliance and accuracy.

The surgical division had started to participate in a national programme sponsored by the NHS for clinical improvement. This was called the ‘getting it right first time’ (GIRFT) programme. The programme identifies the surgical site infection rates of specific procedures within key surgical specialties. In August 2017 the surgical division had started to submit their data. Results to date showed between November 2016 and May 2017 there had been 3.8% (four cases) surgical site infections for elective gall bladder surgery, 4.2% (two cases) gastro-intestinal surgery, 9.5% (two cases) and no surgical site infections for inguinal hernias.

Data provided by the trust showed between May 2017 and October 2017 these figures had improved with surgical site infection rates showing 1.4% (two cases) surgical site infections for elective gall bladder surgery, 4.2% (two cases) and no surgical site infections for gastro-intestinal surgery and inguinal hernia surgery.

In order to measure compliance with trust policies, the infection prevention team (IPT) carried out regular audits. The standard precautions audit incorporated source isolation (a strategy used to prevent the spread of contagious infectious diseases), sharps safety, availability and appropriate use of personal protective equipment (PPE) and measurable elements of the MRSA Policy.

All infection prevention and control concerns were highlighted to the nurse in charge and a written report sent to the ward sister, matron and head of nursing. An action plan was formulated by the ward sister and concerns reported at the site meetings. The action plan was reviewed at the next site meeting to ensure all concerns had been addressed. We saw minutes of these meetings and actions taken, for example in relation to sepsis.

Hand hygiene audits were undertaken to measure compliance with the World Health Organisation’s (WHO) ‘5 Moments for Hand Hygiene’. These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. In data supplied to us from August 2017 compliance for surgical areas was 98%. The trust target was 100%. Four staff out of 100 observed were noted not to be adhering to trust policy. Information provided to us documented the nursing and housekeeping staff identified were reminded of trust policy. However the two medical staff were not reminded according to the documentation.

All wards and departments we visited displayed information regarding individual hand hygiene results and displayed information boards for staff and the public about the importance of hand hygiene. The trust also had a monthly ward health check dashboard which identified hand hygiene rates across all areas on a month by month basis.

There was access to hand washing/gelling and drying facilities on wards and a good supply of personal protective equipment (PPE), which included gloves and aprons. Hand gel was also available at the entrance to all wards we visited. Nursing staff used these items and disposed of them correctly afterwards. We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw that staff followed best practice guidance when giving intravenous fluids and taking blood samples. We saw staff were bare below the elbow to allow for effective hand washing.

We saw patients with infections nursed in side rooms and appropriate signage in place to alert staff and visitors of action they needed to take. Personal protective equipment was provided for staff. Visitors were advised about hand cleansing and wearing gloves and aprons as required.
We observed staff following National Institute of Health and Care Excellence (NICE) clinical guidelines [CG74] 2008 surgical site infections prevention and treatment within theatres. For example, there was hand cleansing gel on entry to anaesthetic rooms. Theatre staff were observed to adhere to best practice principles for ‘scrubbing up’, (rigorous hand and arm washing), prior to surgery and for the management of surgical equipment in the operating environment.

Patients awaiting elective surgery were admitted through the surgical assessment lounge. This was to reduce the possible infection risk to patients already having had surgery. The service had a standard admission criterion for patients admitted and out- lied to elective orthopaedic wards (2017). This laid out the procedures for reducing the incidence of infection due to mixing of both elective orthopaedic patients and medical outliers (medical patients placed in other wards due to a lack of space in specific wards). We saw this in use on Neustadt- Welton ward a medical patient had been out- lied to the ward with a suspected leg infection, it was explained to the patient that this was not the best ward for them and they would need to be nursed in a side room. The ward team then raised this risk with the site managers. To reduce the risk of infection to patients having a joint replacement the patient was transferred. The ward sister we spoke with confirmed that this only happened on rare occasions as all site managers were aware of the transfer criteria. We were told that usually a discussion can be held before potentially inappropriate transfers were made.

We saw that all equipment used by patients was visibly clean and appropriate for use. The trust used ‘I am clean’ stickers for staff to sign indicating where equipment had been cleaned. We reviewed 20 items of equipment; we saw the use of ‘I am clean’ stickers on 18 of these items of equipment. Therefore, we were mostly assured equipment had been cleaned before patient use.

Throughout the hospital, some privacy curtains were non-disposable. Nursing and housekeeping staff told us the schedule for changing them was four monthly but they were changed if visibly soiled or following patient isolation. The disposable curtains had dates on them indicating when they were put up and routine changes were scheduled every four months. In accordance with Health Building Note 00-09: Infection control in the built environment regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known/or suspected infection.

The trust policy for clinical waste disposal was written in line with The Safe Management of Healthcare Waste Memorandum (HTM 07-01) issued by the Department of Health. This recommends the segregation of clinical waste occurs at the point of production using colour coded waste receptacles and outlines a best practice waste segregation colour coding scheme for producers of waste to follow.

We observed staff in all surgical areas at the LCH disposing of clinical, domestic and recyclable waste. All wards and theatres had access to domestic and recyclable waste bags. However, blue clinical waste bins on all ward areas for the disposal of medicines contained other items of non-medicine waste. For example syringes and cardboard packaging, this filled the containers more quickly and increased the cost of disposal to the trust. This had been noted at our previous inspection also. However, staff we spoke with were aware which bins were for what items.

Senior nursing staff we spoke with were aware of the trust policy regarding tap flushing for legionella infection prevention. Legionella is a waterborne bacterium, which causes legionnaires disease. Infrequently used taps and showers were flushed on a daily basis and recorded to monitor compliance. Water testing was completed across the hospital and any areas found to be of higher risk were subject to three times a day flushing and recording. The wards sister reviews it weekly to ensure compliance.

Water coolers were available on wards we visited to supply fresh cool drinking water to staff and relatives. We reviewed three coolers all had been water and safety tested in October 2017.

**Environment and equipment**
There were single rooms available for use on each ward. Priority for these rooms was given to patients who were particularly unwell or needed to be isolated because of infection. The surgical admissions lounge (SAL) was a dedicated suite with a reception, four assessment rooms, eight recliner chairs and 16 trolleys or beds which were used as escalation areas for the emergency pathway in line with the trust escalation policy.

Resuscitation equipment, including emergency medicines, was readily available in all surgical areas and theatres. A difficult airway trolley, providing additional equipment for emergency use, was also available in the theatre suite. Records showed staff signed daily checks for emergency equipment, which were completed in line with trust policy. We reviewed the records for previous months and were assured this was a consistent practice. We opened five resuscitation trolleys and found them all to be stocked appropriately with essential equipment. Re-stocking of resuscitation trolleys was carried out after use or in the event of out of date stock.

Technical equipment used for monitoring patients had been safety tested and stickers indicated the next date for further checks. We reviewed 20 pieces of equipment, for example; blood pressure monitors and hoists; all had been appropriately tested and were within their service date. Electrical equipment we saw had been tested annually as per safety test recommendations.

Clinical areas had limited storage for equipment; however, stock items were kept on each ward for example intravenous fluid pumps. The trust carried out planned maintenance on all equipment stocked on wards. This included items such as, syringe pumps, pressure-relieving mattresses and infusion pumps. Each ward had a set number of specific pieces of equipment. Due to lack of space pressure relieving mattresses due for return to stores for cleaning were left on ward corridors. On Shuttleworth Ward there were three mattresses waiting for return. These were in a bay that had been specially converted for patients living with dementia. The mattresses were not labelled or recorded as waiting for return. The lunch trolley was also being stored in this bay. We were told if patients were using this area these items would be removed. We did not see the area in use during our inspection.

Nursing staff, we spoke with on Hatton Ward highlighted the need for a bladder scanner. They were regularly borrowing one which increased the time patients were waiting for this particular diagnostic scan. We raised this with the Head of Nursing for surgery who assured us that one had been ordered for the department as part of its reconfiguration. Nursing staff we spoke with confirmed that bariatric (equipment for heavier patients) was available. During this inspection there were no patients requiring this type of equipment. However, staff we spoke with told us wheelchairs were available and staff would speak with the manual handling team if they required any further equipment for example specialist beds or hoists.

The surgical division had 10 theatres, three of which were laminar flow (this is a type of air conditioning that reduces air borne infections) including theatres for day case surgery. One theatre was available for emergency surgery 24 hours a day seven days a week. In theatres we found that equipment was kept in good order and stored neatly. Theatres were found to be tidy and well organised. All safety electrical testing of appliances had taken place and were in date. In the equipment store, items were well organised and labelled. Infusion pumps were tested and in date.

Theatre staff reported having sufficient equipment to undertake their roles. For example, equipment trays and patient trolleys.

There was no rolling programme for the replacement of theatre equipment apart from anaesthetic machines. Equipment needing replacing had a service contract and was documented on the directorates risk register. We were told that laparoscopic camera stacks were in the process of being replaced. This was on the risk register.

The difficult airway society launched guidelines for management of unanticipated difficult intubation in 2015. We saw a difficult airway trolley, which contained emergency intubation equipment, was available in theatres. Intubation is the placement of a flexible plastic tube into the windpipe to maintain an open airway. The trolleys contents met guidance and current best practice and we saw daily checks were completed in line with trust policy.
Control of Substances Hazardous to Health (COSHH) was in line with guidance from the Control of Substances Hazardous to Health Regulations 2002. We found hazardous cleaning fluids were always stored in locked cupboards away from patient areas. Ward managers told us COSHH information was available on the intranet and showed us data sheets were available.

Assessing and responding to patient risk

The service ensured risk based pre-operative assessments were carried out in line with guidance on pre-operative assessment for day and inpatient cases.

Patients admitted for emergency surgery were assessed on admission using the American Society of Anaestheologists classification system (ASA). Patients were assessed with regard to their health on admission against six criteria with one being a healthy patient and six being a patient already clinically dead. Theatre staff we spoke with told us consultant anaesthetists and surgeons reviewed all emergency patients. The service ensured there was access to consultant surgeons through the on call system which allocated a named consultant with overall responsibility for the service.

Clinical staff followed the nationally recognised five steps to safer surgery checklist. Staff used a document based on the World Health Organisation (WHO) safety procedures to ensure each stage of the patient journey from ward through anaesthetic procedures, operating room and recovery was managed safely. The recovery theatre team chose a random sample of 100 patients to review (audit) compliance with the documentation. The audit was submitted to the clinical governance department; the results were developed into a WHO checklists dashboard and reported on a monthly basis to the trust board.

Information provided by the trust for January 2018 identified an overall compliance of 100% against a target of 100%. With a cumulative compliance from February 2017 to January 2018 of 98%. The trust identified that failure to complete the ‘sign out’ section was the commonest omission. In order to gain assurance the clinical directors, for each department send out non-compliance assurance letters to the departments. From February 2017 to January 2018, 22 letters were sent out to teams only nine responses were received into the Quality Governance team. However as compliance has improved the plan was to continue with the escalation of letter of non-compliance by the clinical directors.

We reviewed the use of the WHO safety checklist in theatres and whilst reviewing patient medical notes. In each theatre, the checklist was followed and completed by all members of staff. Interventional radiology, breast imaging and ultrasound had also adopted the World Health Organization (WHO) surgical checklist. Staff in interventional radiology told us that use of the checklist had been audited for the three months prior to the inspection which showed that 100% of procedures had had a completed checklist.

Day surgery patients mostly received care in line with the best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011. The Association of Anaesthetists guidance states it is best practice to have a dedicated telephone helpline for patients during the first 24 hours post day surgery. The day surgery unit had a dedicated contact line for patients in place. Advice leaflets were also given to each patient about complications and problems that may occur during the first 24 hours.

During our 2016 inspection United Lincoln Hospitals NHS Trust (ULHT) had a sepsis overview action plan 2016-2017, produced in response to a sepsis review in 2015 after being identified as an outlier with more patients dying from sepsis than expected between December 2014-December 2015. An outlier is when results are below the expected range against the England average. This included the launch of a sepsis bundle in April 2016, providing clear guidance on the detection and treatment of suspected sepsis and an e-learning package for all front line staff. Since then the trust had introduced;

1. Two full time sepsis practitioners with the overall role of providing clinical leadership, raising awareness, ensuring early recognition and intervention and promoting the use of sepsis screening and management tools.
2. Mandatory Sepsis eLearning for all "front line" staff with compliance reviewed and followed up monthly.

3. An education package which included the practical skills required to identify and manage sepsis e.g.; cannulation, venepuncture and blood culture sampling.

4. Standardised electronic observations for adult and maternity inpatients.

5. Introduction of electronic sepsis screening and sepsis Six Bundle based around NICE and Sepsis Trust guidance of risk stratification.

6. A monthly audit of screening compliance and timely bundle completion to monitor compliance with standards identify theme/trends and allow for ongoing development and improvement as required.

7. A monthly, area specific, review of all missed screens and incomplete bundles to identify any possible cases of patient harm, identify theme/trends and allow for ongoing development and improvement as require.

During our inspection we witnessed the timely use of the sepsis pathway. We reviewed the observations for four patients who had scored NEWS of three or above. All patients were appropriately screened for sepsis in line with the sepsis pathway. Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs. Where specific interventions had been required, we saw where the Sepsis Six Care Pathway had been completed in a timely way. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality (death) of patients with sepsis, it consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis for example administering oxygen and intravenous (IV) antibiotics. There were sepsis boxes in all clinical areas we visited.

A National Early Warning System (NEWS) was used for patients across the hospital to assist staff in the early recognition of a deteriorating patient. NEWS is a guide used by medical services to quickly determine the degree of illness of a patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient's condition was deteriorating. We saw NEWS documentation was completed appropriately which meant that patients were being monitored for signs of deterioration and could be treated in a timely way.

During our inspection we reviewed 30 patient observation charts across six clinical areas. Nursing staff adhered to trust guidelines for the completion and escalation of NEWS. All charts reviewed had full observations recorded which included blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output. Pain scores were recorded on all charts reviewed. NEWS had been completed correctly at each time of recording the patient's observations. If patients required fluid balance charts, all of these were up to date and accurately calculated. Patients scoring on their NEWS were required to have further set of observations recorded within a set timescale for example from four hourly to one hourly. Of the 30 charts reviewed, all patients had observations performed in line with the trust ‘escalation of NEWS monitoring in adult patients’ with the exception of one patient who was not for escalation.

We reviewed the observations for four patients who had scored NEWS of three or above. All patients were appropriately screened for sepsis in line with the sepsis pathway. Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs. Where specific interventions had been required, we saw where the Sepsis Six Care Pathway had been completed in a timely way. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality (death) of patients with sepsis, it consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis for example administering oxygen and intravenous (IV) antibiotics. There were sepsis boxes in all clinical areas we visited.
Staff took the time to identify and respond to the changing risks of patients. For example, the adult inpatient care risk assessment booklet included a tissue viability assessment and pathway. Patients assessed as at risk in pre-assessment had a pressure-relieving mattress ordered for the day of admission. This ensured that patients at risk of possible skin damage were identified early and risks could potentially be reduced. The admission booklet also contained a falls multifactorial assessment that included for example, patient history, footwear and eyesight assessments. This ensured all factors that could contribute to a patient’s risk of falls were reviewed. We were told by a relative on the surgical emergency assessment unit of staff responding appropriately to the changing risks of a patient. The patient had suddenly become unwell, staff acted promptly to have the patient seen by doctors and planned emergency surgery before further deterioration. The relative (a nurse) was particularly impressed with the timeliness of all interventions and the communication between the teams.

We observed staff serving lunch on Neustadt-Welton Ward. Food temperatures were checked before serving. This meant food was served at the correct temperature to reduce risks of food poisoning.

**Nurse staffing**

The trust reported their registered nursing staff numbers, as of October 2017, as shown below. For all sites there were 558.9 whole time equivalent (WTE) planned staff and 471.8 WTE staff in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>51.2</td>
<td>43.8</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>258.1</td>
<td>226.3</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>19.2</td>
<td>15.6</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>230.4</td>
<td>186.1</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing)*

**Vacancy rates**

From November 2016 to October 2017 the trust reported a vacancy rate of 16.3% for nursing and midwifery staff in surgery. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>11.5</td>
<td>12.1</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>11.5</td>
<td>15.6</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>11.5</td>
<td>10.5</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>11.5</td>
<td>18.4</td>
</tr>
</tbody>
</table>

Vacancy rates at Louth Hospital were below the trust target; however at all other sites the vacancy rate was higher than the trust target of 11.5%.

*(Source: Routine Provider Information Request (RPIR) Vacancy)*

From November 2016 to October 2017 Lincoln County Hospital reported a vacancy rate of 15.6%. Senior nurses we spoke with on all reported vacancies but felt that they were in a much better position generally than they had been at our last inspection in 2016. The trust had a rolling programme of recruitment, including recruitment from overseas. During our previous inspection recruitment was taking place from European countries. Senior nurses told us that whilst some of these staff remained many of them had either returned home or moved to different areas of the country. The trust had recently recruited qualified nurses from the Philippines. They explained to us that this time the trust had “learnt from the European recruitment in that this time staff were recruited to trust sites according to lifestyle”. Successful candidates from rural towns were matched to Pilgrim Hospital, Boston and recruits from Manilla
were potentially selected to work in Lincoln County Hospital in order that it may be more urban. Recruitment locally was carried out using a cohort process. This enabled teams of staff including human resource representatives to be available all on one day in order to quicken and streamline the process. However, ward staff we spoke with found this a lengthy process generally. The ward manager on Shuttleworth Ward had planned to attend the next cohort interviews in order to attract candidates to the three current vacancies. This involvement in the process would assist choosing staff that may fit into the team dynamics.

Ward managers within surgery explained that they continued to recruit to all vacant posts. Recruitment was mainly from newly qualified nurses that had experience within the departments and had wanted to stay at the trust. This placed an initial pressure on other staff providing support to newly qualified staff however, all ward managers and nurses we spoke with were keen to support and develop these new nurses as part of their teams.

**Turnover rates**

From November 2016 to October 2017 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 6.6% for qualified nursing and health visiting staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate for nursing and midwifery staff is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>1.0</td>
<td>20.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>26.7</td>
<td>20.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>0</td>
<td>20.0</td>
<td>0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>20.2</td>
<td>20.0</td>
<td>7.8</td>
</tr>
</tbody>
</table>

The turnover rate for all sites was within the trust’s target of 20% for an individual staff group.

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

Staff turnover in surgery at LCH was 8.7% from November 2016 to October 2017 (26.7 leavers). This was an increase from 5.7% (23) at our last inspection during 2016. Staff turnover refers to the number or percentage of workers who have left an organisation and been replaced by new employees.

**Sickness rates**

From October 2016 to September 2017 United Lincolnshire Hospitals NHS Trust reported a sickness rate of 4.5% for nursing staff in surgery. The trust’s target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>4.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Sickness rates for qualified nursing and health visiting staff from October 2016 to September 2017 were above the trust’s target of 4.5% at Grantham and District Hospital and Lincoln County Hospital.

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

During our 2016 inspection Lincoln County Hospital reported a sickness rate of 4.4% in surgical
care. This has slightly increased to 4.9% higher than the trust target of 4.5%. Senior nurses told us in order to maintain nurse to patient ratios of 1:8 the use of bank or agency staff is unavoidable.

**Bank and agency staff usage**

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 11.5% with a further 2.6% of shift remaining unfilled. A breakdown by staff type and location is shown below:

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>3,603 (7.8%)</td>
<td>2,971 (6.4%)</td>
<td>1,105 (2.4%)</td>
<td>46,149</td>
</tr>
<tr>
<td>Unregistered</td>
<td>3 (0.0%)</td>
<td>3,961 (18.8%)</td>
<td>1,290 (6.1%)</td>
<td>21,085</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Nursing bank agency)

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times. Patient acuity and dependency data was collected three times per day using a nationally recognised safer nursing care tool. This tool measured the individual dependency of patients and calculated how many nurses were needed to care for them.

National Institute of Clinical Excellence (NICE) guidance (SG1) recommended assessment but did not override the need and importance of using professional judgement to make decisions appropriate to the patient acuity. Staffing on the wards conformed to the one registered nurse to a maximum eight patients guidance suggested by the National Institute for Health care Excellence (NICE).

Fill rates were collected and uploaded monthly to UNIFY as per national policy. These were then sent daily to the senior nursing team and broken down by substantive, bank and agency fill rates. Fill rates were published on the ward’s quality and safety board’s daily so patients and relatives could see them. Fill rates were also reported to the trust board monthly in the nursing and midwifery workforce paper. Staffing levels were also triangulated with quality and safety on a monthly basis through the ward health check.

Each ward at Lincoln County Hospital (LCH) had a ‘safe staffing board’ at its entrance displaying planned and actual staffing. During our visit, all of the wards met the trust requirement of 1:8 nurses to patient ratio. Staff we spoke with on Hatton Ward explained that due to the acuity of their patients since they had dedicated eight beds to care for level one high dependency patients (HDU) staffing ratios were generally 1:8 on the main ward and 1:4 for the HDU patients. This was because of the specialist care required by patients immediately post theatre. The Surgical Emergency Assessment Unit (SEAU) was in the process of dedicating a bay to ambulatory care this would reduce the need for patient overnight stays during assessment and diagnosis of some conditions. In order to facilitate this service staffing ratios were in the process of being reviewed to ensure an advanced nurse practitioner was available on all shifts specifically for these patients.

Senior nurses in main theatres told us there were 5 WTE vacancies at LCH. This had reduced from 14 during our 2016 inspection. Staff told us there was a rolling recruitment programme for theatres and that they regularly use theatre bank staff to cover any remaining empty shifts.

At our 2016 inspection nurses on all wards described their concern regarding the staffing of beds in the surgery assessment lounge (SAL), used for overnight surgical escalation. However, during this inspection, despite the SAL still being used for escalation, all staff understood the need for a substantive member of staff in the area. They generally felt supported when they discussed acuity of patients within their own ward area and felt that decisions were made "with them rather than for them". So whilst staff were still moved they felt communication had improved regarding the process.

Agency and bank staff received a local induction checklist to the ward or theatre area, which included the location of emergency equipment, orientation and working procedures. The nurse in charge signed this with the temporary staff member to confirm completion. The agency/bank nurse induction package also displayed guidelines of how a handover should take place and what should be in it. This was to ensure handovers were consistent and safe at all times.
Nursing handovers were held each day on the wards and in theatres to discuss in detail individual patient needs and risks. This highlighted to staff which patients needed most care and allowed them to gain an oversight of the ward as a whole. A post ward round 'safety huddle' was observed on Greetwell Ward. This updated staff on any changes that may affect patient safety. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care. These huddles and updates were witnessed on all wards we visited and appeared embedded within the safety culture of the surgical areas. We witnessed a huddle in theatres which identified a possible patient safety concern this was then addressed prior to surgical intervention.

**Medical staffing**

The trust reported their medical and dental staff numbers, as of October 2017, as shown below. For all sites there were 391.5 whole time equivalent (WTE) planned staff and 348.5 WTE staff in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>53.0</td>
<td>47.0</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>176.2</td>
<td>165.6</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>158.3</td>
<td>131.9</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing)*

**Vacancy rates**

From November 2016 to October 2017 the trust reported a vacancy rate of 12.0% for medical and dental staff in surgery. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>12.0</td>
<td>14.9</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>12.0</td>
<td>9.3</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>12.0</td>
<td>9.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>12.0</td>
<td>14.2</td>
</tr>
</tbody>
</table>

Vacancy rates at Lincoln County Hospital and Louth Hospital were below the trust target, however at Grantham and District Hospital and Pilgrim Hospital the vacancy rate was higher than the trust target of 12.0%.

*(Source: Routine Provider Information Request (RPIR) Vacancy)*
**Turnover rates**

From November 2016 to October 2017 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 12.2% for medical and dental staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate for medical and dental staff is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>3</td>
<td>20.0</td>
<td>10.4</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>9.6</td>
<td>20.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>0.0</td>
<td>20.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>11</td>
<td>20.0</td>
<td>15.0</td>
</tr>
</tbody>
</table>

The turnover rate for all sites was within the trust’s target of 20% for an individual staff group.

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

**Sickness rates**

From October 2016 to September 2017 United Lincolnshire Hospitals NHS Trust reported a sickness rate of 1.7% for medical and dental staff in surgery. The trust's target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>4.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Sickness rates for medical and dental staff from October 2016 to September 2017 were below the trust's target of 4.5% at all sites.

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

**Bank and locum staff usage**

The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) Medical agency locum)

Surgical doctors, registrars and consultants from all specialities were on call to provide advice and care 24 hours a day. Junior doctors and registrars were available on site during the day, including at weekends. Consultants were on site during the weekdays and were available to attend the hospital out of hours when necessary. We were told on call staff were available when offsite within 30 minutes. There were doctors based on SEAU at all times.

Handovers took place daily, seven days a week for all general surgical and orthopaedic patients. The on call doctors (foundation year two or trust doctor level) had a 30-minute overlap in their shifts, which allowed for a handover of all admissions and any concerns regarding acutely unwell patients.
A theatre meeting took place each morning attended by the anaesthetic team, theatre team, consultant and surgeon on call for the day to decide any changes to the lists. Medical handover for anaesthetics took place twice a day for theatres, which allowed for a review of theatre lists and any concerns to be discussed.

**Staffing skill mix**

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

**Staffing skill mix for the whole time equivalent staff working at United Lincolnshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>31%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>9%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

**Records**

Patient’s individual care records appeared accurate, complete and legible. All members of the multidisciplinary team (MDT) documented in the same notes. This provided consistency when reviewing

Throughout the wards, patient identifiable information was stored in open unlockable trolleys. We could therefore not be assured confidential patient information was safe from access by unauthorised persons. The ward manager on Neustadt-Welton Ward was in the process of purchasing lockable trolleys. However, we were told this was not planned for all surgical wards. Patient plans were documented daily on blue proformas ensuring that staff could immediately identify the current plan for any patient.

We reviewed 20 sets of medical and nursing records. All patient nursing risk assessment documentation was completed appropriately. For example, falls, bed rails, malnutrition scoring and pressure ulcer assessments. Care plans were individualised for 15 out of 20 patients. This meant care may not be tailored specifically to each patient’s needs for example preferred foods. The nursing assessment document did direct staff completing it to “activate and personalise” a care plan in response to issues identified.

Signature legends (a list of names written legibly with an identifying signature), were also available in the nursing admission document. We saw a wide range of staff completing these, including nurses’ occupational therapists and physiotherapists. Doctors on many of the wards had been provided with an ink stamp of their name and general medical council (GMC) number. This ensured correct identification of the doctor that had reviewed the patient. However, doctors without a stamp were not completing the signature legends. Staff we spoke with on SEAU felt that this might have been because it was inside a document, which stated ‘nursing admission’ so doctors did not feel it related to them.
Pre-operative checklists were completed which included a record of consent. These checklists ensure certain safety elements were completed prior to any surgical procedure. For example, patient identification, allergies, correct consent and the time of last food and drink.

All of the wards we visited displayed electronic whiteboards. The touchscreen technology displayed information taken directly from a patient’s electronic record, including clinical alerts such as existing medical conditions, length of admission and predicted discharge date. They also acted as a tracking system to identify what was preventing discharge when patients were medically fit to leave hospital. Previously this information was handwritten on boards when patients were admitted or moved. This required staff to take time out to interpret and re-write a patient’s notes, and increased the risk of inaccuracies during translation. The boards were in full view of the nursing reception area to allow staff to see them at all times, although they were not screen locked by each staff member. This meant that unauthorised people could potentially access the information within them. However, staff told us that this had not happened and that anyone accessing the boards would be challenged for identification if they were not known to them.

**Medicines**

Medicine errors, including those resulting in harm, were reported as part of the incident reporting process. Medication incidents were reported on a monthly basis to the medicine optimisation and safety committee. The top two reasons for raising incidents were omitted medicine and wrong dose prescribed.

Staff described the process for identifying and reporting errors via an online reporting system and we discussed reporting levels. Ward sisters advised that missing signatures were the most common issue identified by ward assurance processes and, if not resolved, the specific incident would be reported the incident reporting system. Staff we spoke with reported good awareness of incidents occurring on their ward and across the trust.

Staff were able to discuss incidents where errors had occurred and described the actions taken to help prevent a similar error. For example, medication charts were checked at staff handovers to ensure missed doses or signatures could be identified immediately. We saw ward managers also completed a three times weekly ward assurance checklist where medication charts were also reviewed for accuracy.

When there were staff shortages the trust had implemented a ‘floating pharmacist’ arrangement at Lincoln Hospital where a pharmacist was available by a bleep system to visit wards to authorise medicines for dispensing. This avoided the need for prescription charts to leave the wards. This had been introduced to reduce the risk of medicines being omitted due to the charts not being available.

Wards were visited by a pharmacy technician daily and usually a pharmacist. If there were concerns outside of the usual visit time staff could be bleeped. We were told that charts rarely need to leave the wards now in contrast to the situation 12 months ago. Delays for obtaining discharge medications (TTOs) sometimes occurred for controlled medicines but this was generally not related to pharmacy processes. Controlled medicines are medicines controlled under the Misuse of Drugs regulations 2001 these legal controls govern how controlled medicines should be stored, produced, supplied and prescribed.

Nursing staff confirmed they had access to regular pharmacy advice. The pharmacists visited the wards daily Monday to Friday, to check prescription records and raise any queries with doctors. Staff on all surgical ward areas told us they received a visit from a pharmacist in the afternoons. However, this was not always timely to facilitate same day discharges.

We saw that the number of charts going to the dispensary each day at Lincoln Hospital had more than halved from over 100 to between 40 and 50. We spoke to senior members of the pharmacy team who advised us that details of this service had not been disseminated across the trust so some staff on wards were not aware of this service.

One ward- Shuttleworth – reported a poor pharmacy service with significant delays in obtaining TTOs due to delays in the dispensary – this was investigated whilst we were on site by examining the ‘tracker’ system.
over the past week for patients from this ward. The concerns expressed by the staff nurse were not substantiated by this investigation. This perception may have arisen due to changes in pharmacy staff visiting the ward and timings for those visits having altered.

One ward- Shuttleworth – told us that they were no longer able to use the self-administration of medicines tool (SAM), since June/July 2016 due to lack of pharmacy staff availability to check risk assessments. We noted that there was a SAM policy in place across the trust and that it was being used on other wards – this information was reported in writing back to the ward sister on the ward. This highlights a concern that information may not be effectively disseminated to all wards when policies are altered or introduced.

There were local microbiology protocols for the administration of antibiotics. The pharmacist monitored antibiotic prescribing to ensure patients were prescribed antibiotics in accordance with these protocols and a microbiologist was available to advise doctors with antimicrobial selection.

Medicines inspectors reviewed 33 medicines charts and saw that antibiotics were prescribed with stop dates supporting good antimicrobial stewardship, patient allergies were identified and wristbands were in place. From the 33 charts we looked at we identified 13 medicines with no signature or code against the administration on one or more occasions. Therefore records could not assure us that patients received their medicines as prescribed and this included some critical medicines (e.g. anticoagulants, antiepileptic medicines and antibiotics).

We identified one patient whose VTE assessment had not been acted on and no prophylaxis had been provided (admitted six days previously) – this was escalated to a doctor on the ward and rectified during our inspection.

We reviewed medication charts for 25 patients and found them to be complete, up to date, and reviewed on a regular basis by the pharmacist. Patient’s weight and any allergies were also recorded. Records showed patients were getting their medicines when they needed them. We observed nurses administering medication, checking doses and names. Nurses wore red aprons to indicate they were carrying out medication rounds and should not be disturbed.

Staff knew about the five rights of medication administration. One of the recommendations to reduce medication errors and harm is to use the “five rights”: the right patient, the right drug, the right dose, the right route, and the right time. (Institute for Healthcare Improvement 2007)

Controlled medicines, on the wards and in theatres were stored appropriately and drug records were accurately completed. Emergency medicines were available for use and these were in date and replaced by pharmacy when used. The service carried out quarterly controlled drugs audit in the operating theatres to ensure controlled drugs were stored and checked appropriately.

Disposal arrangements were in place for out of date medicines, or medicines, which were no longer required. Medicines were disposed of in blue medicine disposal bins or returned to pharmacy. Intravenous fluids were stored in locked cupboards in treatment rooms on wards. This reduced the risk that intravenous fluids could be tampered with or accessed by unauthorised people. On one ward fluids containing potassium were stored in close proximity to other fluids but were segregated using a sectioned off area marked in red, on another ward staff had removed the potassium containing fluids however they had moved them to an unlocked area. This was addressed with the ward manager at the time and a lock was to be fitted. This contravenes guidance issued following the 2002 National Patient Safety Agency alert specifically about storage and handling of potassium chloride concentrate and other strong potassium solutions.

There were arrangements in place for the storage and management of medicines in surgical areas, including theatres and recovery. However, Neustadt-Welton Ward had a clinic room, which often became very warm. In order to monitor and maintain safe storage of medications, a room thermometer was in place and we saw temperatures were checked daily. An air conditioning unit was in place to use if temperatures rose above the recommended storage temperature of 25 degrees Celsius. The temperature monitoring charts were compliant line with March 2005 Royal Pharmaceutical Society; The Safe and Secure Handling
of Medicines: A Team Approach. The ward was also in the process of having a reflective coating applied to all windows to reduce the heat on the ward.

Medicines requiring refrigerated storage were stored at the correct temperatures to ensure they were fit for use. On all of the wards we inspected, the temperature checks for the medication fridges were undertaken by the ward teams. Fridge temperatures were recorded, including current lowest, highest and actual. Because of this, we could be assured medicines were stored safely. We saw on one ward that the temperature of the fridge had increased to 10 degrees Celsius on two occasions the previous month. We saw it was documented on the chart actions taken (removal of medication) and a repair of the fridge.

Hypo-boxes were available for the emergency treatment of hypoglycaemia. The boxes were checked daily and sealed with a tamper evident seal.

**Incidents**

**Never Events**

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

From January 2017 to December 2017, the trust reported one incident classified as a never event for surgery. This was a retained foreign object post procedure.

The never event reported related to the retention of a Kirschner wire (k-wire - these surgical wires are used to hold bones in place post-surgery). The incident investigation for this never event included a root cause analysis (RCA). An RCA is a method of problem solving used for identifying the causes of faults or problems. The RCA highlighted incorrect checking of implants during surgical procedures. Following this never event, the trust implemented an additional count for k-wires and have sourced a new drape which does not contain this wire.

During our inspection, theatre staff told us about these changes and staff on the wards were also able to explain what the never event was.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 69 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Pressure ulcer meeting SI criteria with 26 (37.7% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 10 (14.5% of total incidents).
- Slips/trips/falls meeting SI criteria with 10 (14.5% of total incidents).
- Treatment delay meeting SI criteria with 10 (14.5% of total incidents).
Site specific information can be found below:

**Lincoln County Hospital**

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Total incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>13</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>5</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>4</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>3</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>3</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>2</td>
</tr>
<tr>
<td>Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the surgery directorate for this trust reported 31 serious incidents (SIs) which met the reporting criteria set by NHS England during January 2017 and December 2017. Of these, the most common type of incident reported was pressure ulcer meeting SI criteria (13 incidents).

In order to address the problems with pressure ulcers a tissue viability nurse consultant at the trust had developed a pressure ulcer notification tool (PUNT), an online system that allowed clinical staff to report and review reliable pressure ulcer data for hospital inpatients. All pressure ulcers above a grade two were reported on an incident form and on PUNT in order to understand the mechanism and how the ulcer could have been prevented. This information was then fed back to ward teams in order to develop further awareness of pressure ulcer management. Data from March 2016 showed pressure ulcer incidences for all hospital admissions at 0.5%, down from a peak of 6% since PUNT was first introduced.

We saw a copy of the trust incident policy, which clearly outlined the process for reporting and managing incidents. Incidents were reported through the trust’s electronic reporting system. All the staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust’s electronic reporting system. Incident themes included falls, pressure ulcers and medication errors or omissions.
Ward and theatre staff were able to give specific examples of learning from incidents and most staff told us they received feedback after reporting an incident. All ward managers and managers said they provided feedback through email and newsletters and during ward meetings. We reviewed minutes of monthly ward meetings during our inspection, which included feedback around reported incidents.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ’notifiable safety incidents’ and provide reasonable support to that person. The trust had a “being open and duty of candour policy” Staff on most wards could describe an incident where duty of candour applied. An example of this was after the never event an apology from the surgical team was sent.

Within the individual clinical directorates for the different surgical areas, morbidity and mortality, (M&M) meetings were held monthly. These meetings reviewed patient deaths and treatment complications, in order to develop improvements to patient safety and aid professional learning. Reports were graded 0-3 where grade 2’s were ‘probably unexpected’ and grade 3’s were ‘unexpected deaths’. Minutes reviewed for January 2018 demonstrated all unexpected deaths were discussed and trends identified. An action log was created to ensure all actions were followed up and completed in a timely manner. This included any communication with other trusts and services.

The trust’s mortality review assurance group (MoRAG) further reviewed all mortality reports graded at one or above. This was a multidisciplinary team of ULHT Clinicians, Nursing and Quality Leads including local commissioners. We reviewed minutes from the MoRAG meetings between December 2016 and November 2017 and found each review detailed any issues flagged by the MoRAG review and where applicable any actions required were taken forward.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported 49 new pressure ulcers, 31 falls with harm and nine new catheter urinary tract infections from November 2016 to November 2017 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at United Lincolnshire Hospitals NHS Trust**

![Graph showing total pressure ulcers and falls](image)
The rate of pressure ulcers recorded in the patient safety thermometer has varied over time but there has been no upward or downward trend over the period. The rate of falls recorded has fallen over the period and the rate of urinary tract infections in patients with a catheter (CUTIs) has remained similar.

(Source: NHS Digital)

The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and harm free care. Data is collected on a single day each month to indicate performance in key safety areas. It focuses on four avoidable harms: pressure ulcers (PU), falls, and urinary tract infections in patients with a catheter (CAUTI), and blood clots or venous thromboembolism (VTE). VTE is the formation of blood clots in a vein. Each surgical ward collected information on a range of safety measures based on individual patient risk assessments.

The results were part of each ward’s performance monitoring and included information such as number of inpatient falls, number of hospital acquired pressure ulcers in each of the recognised pressure ulcer grading categories (grade one to four, with one being superficial and four being deep) and also the number of medication administration errors. We saw this information displayed within all of the wards. Patients and visitors could therefore see how the ward was performing in relation to patient safety.

Ward managers and matrons attended a monthly meeting to discuss performance and plan actions for their areas in relation to patient safety. Where an increase in patient harm had been identified in a ward area, ward managers told us they would raise this with staff via email, newsletters and at ward meetings. Each matron had a monthly quality report for their area. This detailed any issues or concerns for each ward area. For example, there was an overview of ‘hotspot concerns’ and mitigations and then more specific items for each ward area. Falls had increased on one ward area, in order to address this accountability letters had been sent to all members of staff and falls training had been increased. Within this it had been identified that monitoring of lying and standing blood pressures was not consistent across all areas. This was then taken forward by the matron to address on all ward areas in order to potentially further reduce falls.

The National Institute for Health and Care Excellence (NICE) Quality Standard (QS) three, statement one states all patients, on admission, should receive an assessment of VTE and bleeding risk. The trust’s performance report for December 2017 showed 95% of VTE assessments were completed on admission. Within surgery, completion was 95%. This met the trust’s target of 95%.

Is the service effective?

Evidence-based care and treatment

Patients care needs were assessed throughout their care pathway. Care and treatment was delivered in line with ‘National Institute of Health and Care Excellence’ (NICE) quality standards and the Royal College of Nursing guidelines. For example, the use of National Early Warning System (NEWS), complied with the recommendations within NICE guidance CG 50 acute illness in adults in hospital: recognising and responding to deterioration.

Policies were up to date and followed guidance from NICE and other professional associations for example, the Association of Perioperative Practice (AfPP). Local policies, such as infection control policies were written in line with national guidelines. Staff were aware of these policies and knew how to access them on the trust’s intranet.
We saw examples of policies and procedures, which were based on nationally recognised guidance. The inpatient care and risk document, completed for every patient, contained the malnutrition universal screening tool (MUST); this identified adults who were underweight or at risk of malnutrition. A nationally recognised screening tool was used to identify patients at risk of developing pressure ulcers and a falls multifactorial assessment that included for example, patient history, footwear and eyesight assessments.

The adult inpatient risk assessment booklet also included information on how to recognise a pressure ulcer and a flow chart for completion guidance for each risk assessment. We reviewed 20 sets of medical/nursing notes and all appropriate risk assessments were completed.

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend patients with certain co-morbidities (multiple medical conditions) are reviewed pre-operatively by an anaesthetist. Examples include age, heart disease (myocardial infarction and angina), heart failure, ischaemic brain disease (stroke and transient ischaemic attacks). The majority of patients with multiple medical conditions or increased complications of anaesthesia were seen in a pre-assessment clinic with access to an anaesthetist. Staff in theatres told us this amounted to only 20% of all patients. Whilst this ensured patients at high risk of complications were prepared for the procedure and an appropriate anaesthetic selected prior to surgery. For example, some surgical procedures were carried out under a spinal block eliminating the risk of general anaesthesia. (Spinal block is a form of localised anaesthesia involving the injection of a local anaesthetic into the back). We saw documentation and spoke with two patients who had attended this clinic. Nurses in the clinic told us that they would always speak with an anaesthetist if there were any concerns.

During admission, comprehensive care pathways were in place for patients undergoing anaesthesia for surgery, including localised and general anaesthesia. Care pathways are multidisciplinary plans of anticipated care and timeframes. This meant there was a standard system in place for each patient admitted.

An enhanced recovery procedure was in place for patients having hip, knee, or colorectal surgery. Enhanced recovery is an evidence-based approach that helps people recover quickly following major surgery. We saw a copy of the enhanced recovery checklist for colorectal patients, which included information for the patient on what they could expect before and after surgery and discharge information. The colorectal nurse specialist saw patients’ pre surgery and food supplementation was given. The elective orthopaedic patients were prescribed pre surgery analgesia (pain relieving tablets) and were consented for the national joint register as part of the enhanced recovery programme. Surgical staff were observed to be following the National Institute for Health and Clinical Excellence (NICE) guidelines for the prevention and treatment of surgical site infections. The surgical site infection surveillance team (SSIS) monitored surgical site infection in the following areas, total knee replacement/revision and total hip replacement/revision.

Across the surgical division, we saw there were arrangements in place aligned to the Royal College of Surgeons (RCS) standards for unscheduled surgical care and emergency surgery. Examples included a dedicated surgical assessment unit, a consultant-led service with consultant availability at all times for telephone advice, a dedicated surgical team free of elective commitments to cover emergencies and emergency theatre availability at all times. United Lincolnshire Hospitals Trust (ULHT) followed NCEPOD, (National Confidential Enquiry into Patient Outcome and Death) guidelines for patients requiring emergency operations after 10pm. This meant patients, operated on after 10pm, were recovered in theatre and then returned to a surgical ward. ULHT reported one occurrence of a patient staying in recovery overnight at Lincoln County Hospital (LCH).
Nutrition and hydration

Fluid balance charts were in place to monitor patients’ hydration. We reviewed 13 fluid intake and output charts and found that all were fully completed. This meant that patients’ fluid requirements were monitored accurately.

All patients had their nutritional status assessed within 24 hours of admission using the malnutrition universal screening tool (MUST). The MUST tool calculates the overall risk of malnutrition. Patients considered a lower risk of malnutrition were scored and a prompt was given for nurses to assess and monitor then repeat the assessment after three days. The booklet then advised the nurse further on what to do in certain circumstances. For example, if the patient has swallowing difficulties refer to the dysphagia (swallowing difficulty) nurse specialist.

Ward staff told us that although a dietician did not necessarily visit the wards daily they knew how to contact the team if necessary. The assessment and MUST tool offered a guide to assist the nursing staff in deciding if a dietician referral was required. Staff told us that dietitians were easily accessible and responded promptly to referrals from nursing staff.

There was a hospital nutrition team that consisted of a pharmacist and a dietician. They would visit and review all patients receiving total parenteral nutrition, (TPN). This is the feeding of a patient through a vein, bypassing the usual process of eating and digestion. The patient would receive nutrients such as glucose, salts, added vitamins and dietary minerals. We saw evidence in medical notes from the nutrition team changing feed prescriptions according to blood test results and requesting further monitoring of bloods. They also recorded their contact details and the date they were going to next review the patient.

All qualified staff nursing patients on TPN had received training in management and care of the specialist intravenous lines.

We reviewed five food charts on Greetwell Ward and one on Clayton Ward, all were fully completed. Two patients were being monitored by the nutritional support team and were receiving TPN.

In the pre-assessment clinic patients were given information about when they must stop eating and drinking before their operation. Depending on the surgical procedure, patients could drink clear fluids up to two hours before surgery and eat up to four hours before surgery.

At our 2016 inspection nursing staff said medications for post-operative nausea and vomiting (PONV) were not routinely prescribed. However all 25 medication charts we reviewed during this inspection had PONV treatment prescribed. Patients we spoke with reported they had received PONV treatment when they needed it.

Pain relief

Lincoln County Hospital (LCH) fully complied with all of the standards set out by the Faculty of Pain Medicines Core Standards for Pain Management (2015). For example standardised assessment tools and clear protocols for the management of acute pain by ward staff. The trust had worked towards implementation of all recommendations, particularly those in relation to managing pain in the community. They also regularly liaised with other local pain services through the midlands pain forum.

A dedicated pain management team consisting of three specialist nurses covering the hospital could be contacted by bleep/pager. The team included nursing and medical staff. They were available 8am-5pm Monday to Friday, over the weekends this service was covered by anaesthetists. All patients who required major elective surgery were referred to the pain nurse pre-operatively who then visited patients following their operation.

Following surgery, appropriate pain relief was administered in theatre recovery. Patients undergoing orthopaedic surgery had pre-planned pain relief prescriptions. Pain control was discussed with patients pre-operatively and documented in the multi-disciplinary team notes.
Five patients on the surgical emergency assessment unit told us nurses responded quickly to requests for pain relief and staff returned to ask if their pain had been relieved. During our inspection, we saw nurses on medication rounds asked each patient about their pain and administering analgesia as prescribed. In all 25 medication records we reviewed pain relief medication had been prescribed and given appropriately.

In the 20 adult inpatient nursing assessment booklets we reviewed, all of them had completed the on admission pain assessment and documented where appropriate the patient’s pain score using a 0-3 pain score. In seven of the charts pain was identified as a problem for the patient. This should have initiated the use of a pain care plan for the patient. There was a pain care plan for six out of the seven patients. This assured us that pain was managed effectively for the majority of patients we reviewed. However, the patient without the pain care plan was also receiving regular analgesia as prescribed and there was no evidence of discomfort in the medical/nursing documentation.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From September 2016 to August 2017, the trust had a lower than expected relative risk of readmission for elective admissions when compared to the England average. However when comparing the trust to the England average at specialty level (for the most common three specialties at the trust) Trauma & Orthopaedics patients had a higher than expected relative risk of readmission for elective admissions.

The trust had a lower than expected relative risk of readmission for non-elective admissions when compared to the England average. For all of the three most common specialties at the trust the relative risk of readmission for non-elective patients was lower than the England average.

**Elective Admissions – Trust Level**

![Graph showing relative risk of readmission for elective admissions by specialty for the trust and England average.](image)

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

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Lincoln County Hospital

From September 2016 to August 2017, Lincoln County Hospital had a lower than expected relative risk of readmission for elective admissions when compared to the England average. However when comparing the hospital to the England average at specialty level (for the most common three specialties at the hospital) Urology and ENT patients had a higher than expected relative risk of readmission for elective admissions and the risk of readmission was lower than expected for General surgery.

The hospital had a lower than expected relative risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - Lincoln County Hospital

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

Non-Elective Admissions - Lincoln County Hospital

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

**Lincoln County Hospital**

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 5.6% which was within the expected range. The 2016 figure was 8.6%.

80.1% of patients had surgery on the day of, or day after admission, which falls in the middle 50% when compared to other hospitals that participated in the audit. The 2016 figure was 82.3%.

The perioperative medical assessment rate was 96.3%, which falls in the middle 50% of all hospitals that participated in the audit. The 2016 figure was 91.5%.

94.3% of patients were documented as not developing a pressure ulcer which put the hospital in the bottom 25% of all hospitals that participated in the audit. The 2016 figure was 97.5%.

The length of stay was 17.7 days, which falls in the middle 50% of all hospitals that participated in the audit. The 2016 figure was 19.0 days.

The national hip fracture audit 2017 showed 99% of patients in this group were seen by an orthogeriatrician which was better than the England average of 89%. The audit also showed that 96% of patients in this group received physiotherapy assessment prior to surgery which was better than the England average of 90%.

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 69.0% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 78.9%.

The risk-adjusted 90-day post-operative mortality rate was 7.0% which was within the expected range when compared to other hospitals that participated in the audit. The 2015 figure was 6.9%.

The risk-adjusted 2-year post-operative mortality rate was 29.4% which was within the expected range when compared to other hospitals that participated in the audit. The 2015 figure was 22.6%.

The risk-adjusted 30-day unplanned readmission rate was 14.9% which was within the expected range when compared to other hospitals that participated in the audit. This was not reported in the 2015 report.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 75.1% which was a negative outlier when compared to other hospitals that participated in the audit. The 2015 figure was 85.6%.

(Source: National Bowel Cancer Audit)

The trust monitored the outcome of patients who had operations for bowel cancer by participating in the national bowel cancer audit. In 2016 patient’s outcomes were compared with patients who had the same operation at other hospitals. Patients at this trust were likely to spend longer in hospital after their operation than in other hospitals. The colorectal nurse specialists at this Trust had audited length of stay and local data for January 2018 identified that since a change of post-
operative patient management at Lincoln County Hospital the early indications were that length of stay had reduced by 3.5 days from 8.5 (January 2017) to 5 days (January 2018). The team were hopeful that this improvement would be maintained and be evident in the next national bowel cancer audit.

Patients who had an operation for bowel cancer at this trust were just as likely to survive as they would if they had the same operation in the majority of hospitals in the country. Survival rates were compared at three months and at two years after their operations.

**Oesophagus-Gastric Cancer National Audit**

In the 2016 Oesophagus-Gastric Cancer National Audit (OGCNCA), poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The trust was not eligible for the 90-day post-operative mortality rate.

The proportion of patients treated with curative intent in East Midlands Strategic Clinical Network was 42.5% which was significantly higher than the national aggregate. This metric is defined at strategic clinical network level. The network can represent several cancer units and specialist centres. The result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

*(Source: National Oesophagus-Gastric Cancer Audit 2016)*

**National Emergency Laparotomy Audit**

Lincoln County Hospital participated in the 2016 national emergency laparotomy audit (NELA). (A laparotomy is an operation performed on the abdomen) The audit compared the care and treatment of 181 patients at Lincoln County Hospital to patients in 185 other hospitals. The audit looked at the care before, during and after operations

**Lincoln County Hospital**

In the 2016 National Emergency Laparotomy Audit (NELA), 66% of 181 cases had pre-operative documentation of risk of death. This was below the national standard of 80%.

78% of 138 cases had access to theatres within clinically appropriate time frames. This was below the national standard of 80%.

93% of 105 high-risk cases had a consultant surgeon and anaesthetist present in the theatre. This was above the national standard of 80%.

98% of 64 highest-risk cases were admitted to critical care post-operatively. This was above the national standard of 80%.

However, since this data was collected the post-operative pathway has now changed for some of these patients. Hatton Ward now has dedicated beds for level one patients’, (those at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.) This means that patients that were originally allocated a default critical care bed may be treated on Hatton ward.
The risk-adjusted 30-day mortality was 12.7% based on 181 cases. This was within the expected range when compared to other participating trusts.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 the proportion of groin hernia patients who reported an improvement following surgery was similar to the England average.

The trust performed worse than the England average for the proportion of patients who reported an improvement or a worsening following surgery for hip replacements, knee replacements and varicose veins.

*(Source: NHS Digital)*

Anaesthetic provision followed the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists guidance. The trust had not applied for Anaesthesia Clinical Services Accreditation (ACSA). This is a voluntary scheme for NHS and independent sector organisations offering quality improvement through peer review.

The surgical business units at LCH were participating in local audit. For example, an audit monitoring hypothermia prevention in surgery (NICE CG56). We saw minutes of meetings where the anaesthetists audited compliance with the clinical governance guidance (CG65) ‘Hypothermia: prevention and management in adults having surgery’. The audit showed 91% compliance with the guidance. The minutes also noted 75% compliance with the NICE guidance (NG45) ‘Routine preoperative tests for elective surgery’.
Audit information was also provided by the trust before our inspection. For example, Trauma Audit Research Network (TARN), this audit was collecting data for trauma admissions accepted into the trust and patients access to diagnostic scans. This audit was ongoing and all trauma meetings were to include case reviews for shared learning. Another audit was a reaudit of the Management of Elective Colorectal Surgical Patients Enhanced Recovery it had identified preoperative optimisation of patients with 100% compliance with antibiotic prophylaxis using a single dose covering both anaerobic and aerobic organisms. Reduced use of epidural anaesthesia and improved preoperative preparation and documentation. The trust guidelines were to be rewritten as a result of this reaudit.

Competent staff

Appraisal rates

The trust provided appraisal rates for staff who required an appraisal from April 2017 to October 2017. As most appraisals are carried out at the end of the financial year figures do not include all staff members. From April 2017 to October 419 staff were required to complete an appraisal with 83.5% of these having received an appraisal. This was lower than the trust target of 85%.

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

At Lincoln County Hospital 471 surgery staff were required to complete an appraisal with 71.1% of these having received an appraisal. This did not meet the trust target of 85%. 75.6% of qualified nursing and health visiting staff had completed an appraisal and 100% of medical and dental staff had received an appraisal.
A split by staff group can be seen in the graph below:

![Graph showing a split by staff group with percentages on the y-axis and staff categories on the x-axis.]

Provider Information Request (RPIR) Appraisals

The trust had systems in place to ensure that the registration status of qualified doctors and nurses’ had been renewed on an annual basis. There was a nominated responsible officer for medical revalidation. Nurses we spoke with told us there were learning events to help with revalidation.

New nursing staff told us they attended a corporate induction and local induction when they commenced employment at the trust. The trust target for attendance at the corporate induction was 95%. New staff nurses were also given four weeks supernumerary status to assist them in settling in to the new trust and familiarising themselves with policies and procedures.

An induction folder was used on the wards for bank and agency staff. Areas covered on the induction included working procedures, ward orientation and medicine administration. The log on two wards we looked at was completed sufficiently to indicate bank and agency staff had been orientated to the ward or clinical area. Ward managers showed us evidence that bank and agency nurse competency was reviewed prior to any shifts. For example evidence of competency in intravenous (IV) medication had to be provided before agency staff were permitted to use this skill.

All wards within the surgical business units had a senior nurse with some protected time dedicated to clinical education. We saw documentation on Clayton Ward, which identified the specialist training the nursing team, had undertaken. For example, an on-line tracheostomy training package provided by the National Tracheostomy Safety Project which was developed in conjunction with the Department of Health e-learning for health care project. However staff told us that clinical education time was often reduced in order to cover ward shifts, due to sickness.

Within the surgical division at Lincoln county Hospital (LCH), as of October 2017, completed staff appraisals were reported to be an average of 65%. Against a target of 85%. Individual area data was as follows:

- Hatton Ward 61%
- Clayton Ward 50%
- SEAU 88%
- Shuttleworth 61%
Greetwell Ward 88%
Neustadt Welton Ward 82.5%
Main Theatres 84%
Surgical Admissions Lounge 100%

All areas were on target to complete appraisals as planned and we saw evidence where appraisals had been planned onto rotas to ensure time was available without affecting clinical numbers.

All the staff we spoke with described their appraisal as a positive experience, which enabled them to identify their learning needs for the following year. For example, mentor training, and associate nurse training.

Staff told us whenever possible they were allocated time to attend training sessions or complete on line training and we saw this in practice. During our inspection, a nurse returning from a period of sickness was undertaking mandatory training updates as part of a return to work programme.

Advanced nurse practitioner (ANPs) were in post in the surgical emergency assessment unit and the orthopaedic wards. Additional nurse training and education had enabled ANPs to carry out patient consultations and physical examinations, develop a differential diagnosis and prescribe where appropriate.

We spoke with three ANPs they were all very supportive of each other and aware of the development of the role in order to support both the medical and nursing teams. The senior nurses on SEAU and Neustadt-Welton Ward explained the benefit of having an ANP available, always having someone with clinical expertise around providing continuity for the patients and the medical staff.

Three out of four junior doctors in surgery we spoke with told us they attended teaching sessions and participated in clinical audits. We observed good interactive learning taking place during a patient ward round between the consultant and a junior doctor and an ANP.

Junior doctors told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns. Two junior doctors we spoke with told us that covering nights and weekends was difficult as they were often the only junior doctor on duty. On further investigation it was noted that they were part of a team of senior nurses and ANPs. The workload was allocated between the team according to skill requirements. All of the patients who spoke with us reported a high level of confidence in medical and nursing staff with regard to their knowledge and their skills.

Housekeeping staff and nursing staff handling food told us they had received food hygiene awareness training. The Food Safety and Hygiene (England) Regulations 2013 require that all “food handlers” are trained and/or supervised and instructed in food hygiene. This meant the trust were adhering to regulations.

**Multidisciplinary working**

There was good multidisciplinary team (MDT) working across surgical areas. We saw particular evidence of this on Hatton Ward. For example, in order to plan and provide care and treatment for a patient, advice and involvement was required from the nutrition team, colorectal nurse specialist, a junior doctor and a staff nurse. We witnessed them working together in order to provide the best possible outcome for the patient.

At our 2016 on most wards we described the MDT meetings as “adhoc”. During this inspection there appeared to be much more emphasis on shared meetings and huddles to discuss patient safety and any changes in care. The MDT discussed each patient’s condition and progress on a daily basis.

There were weekly multidisciplinary team (MDT) meetings per speciality with representation from radiologists, surgical team, oncologists and nurse specialists. Newly diagnosed patients, post-operative patients and onward referral of patients were discussed to ensure continuity and consistency of care. Electronic white boards were in use on all surgery wards to indicate which patient required specialist input and were updated at least twice daily following ward rounds and reviews. We witnessed porters recording on these boards when they had taken a patient off the ward for an x-ray or to theatre for example.

Doctors (foundation year two) confirmed they were on call once or twice a month and were well supported by the registrar and consultant team.

Two ward rounds were seen being completed in the morning and late afternoon with the medical, nursing staff. This ensured that the patient’s needs were met as the patient’s care was reviewed. On Hatton Ward a
consultant intensivist also did a daily ward round of all level high dependency patients. Consultant surgeons we spoke with were pleased that they were able to maintain oversight of the higher dependency patients now that care was managed jointly for these patients on Hatton Ward.

Patients were admitted under the care of a consultant who has overall responsibility for each individual's care. The service ensured that access to consultants were available when needed through the roster and on call rota. The service met the objectives introduced following the Francis report with the release from the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients (June 2014) which was implemented by each patient having care under a named clinician and that a named nurse is identified for each patient to improve quality of care. Those names were seen on in the patient's care plan, however not always on boards behind the patients' bed.

The physiotherapists and occupational therapists supported patients after surgery and for assessments prior to discharge home. Physiotherapy staff we spoke with felt they had continuity of patient care and MDT working as they usually covered the same wards. However, we were told occupational therapy (OT) staff worked on an individual patient basis. Occupational Therapy staff told us there was effective communication and partnership working between the surgical/orthopaedic teams. All patients requiring OT and physio would be identified on the electronic whiteboard. This could be accessed from any department so led to improved communication.

Staff worked together to assess and plan ongoing care and treatment in a timely way when patients moved between teams, services or hospital sites. Surgery services were based at four hospital sites of the trust. MDT working within specialist services for example, the pain team and the tissue viability nurse specialists involved linking between the sites. All staff we spoke with felt that the services were available in a timely way despite not necessarily being present at the LCH site. Staff in pre assessment told us that at our previous inspection they had little knowledge of what went on at the pilgrim site. However, they were now much more informed about was happening on other sites and actively tried to ensure patients that might have missed an appointment could be seen at another site.

**Seven-day services**

Operating theatres were available seven days a week. An on call rota was in place for surgical and anaesthetic teams. These staff could attend within 30 minutes if needed in the out of hour’s period between 1am and 8am. Surgical consultants worked an emergency on call rota, seven days per week. A consultant was on call every day Monday 8 am to Sunday 5pm. This maintained continuity for patients within the clinical directorates) and on the ward. Ensuring patients were reviewed over weekends and bank holidays. This was in line with priority clinical standard six, consultant access.

We reviewed 20 sets of patient medical notes and all of them showed evidence of a clinical review from a consultant within 12 hours. This was in line with priority clinical standard two, review within 12 hours.

Seven-day access to an ortho geriatrician, (a doctor that looks after elderly orthopaedic patients), is a key priority in NICE guidance CG124 (hip fracture management). Senior Staff told us that covering weekends with an ortho-geriatrician was extremely difficult, due to national shortages, but that it would benefit patients if it were available to reduce admissions at the weekend and to improve continuity of care across the service.

Physiotherapy services were provided seven days a week and an on-call system was in operation if they were required out-of-hours.

Ward based pharmacists visited the wards Monday to Friday to review medication charts and a pharmacy on-call system was in operation weekends and out of hours.

**Health promotion**
Staff supported patients, and their relatives where appropriate, to manage their own health and wellbeing, and to maximise their independence following surgery. We saw enhanced recovery programmes that enabled patients to be actively involved in the recovery phase following surgery. Part of this pathway included encouraging patients to be as healthy as possible before their planned operation.

Patient records we looked at showed that staff in the surgical pre-assessment unit discussed eating well, exercise, relaxation, smoking cessation, and alcohol consumption and the importance of trying not to worry too much about the surgery. People who were smokers were referred to the smoking cessation services. However, the trust did not provide smoking cessation products to patients at the pre-operative phase.

Information leaflets for all surgical procedures carried out at Lincoln County Hospital were available and provided to patients at pre-assessment clinic. These leaflets included how to ensure health prior to admission to hospital.

We observed one patient being pre-assessed prior to surgery which included the prevention of deep vein thrombosis and pulmonary embolism (blood clots in the veins and lungs) and what to watch for when they went home.

We saw patient leaflets on the wards such as diabetes care and how to look after foot ulcers. There was also information about home meals services where meals could be delivered directly to a patient’s home once they were discharge.

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

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

Deprivation of Liberty safeguards training at the trust is completed as part of the Mental Capacity Act (MCA) level 2 training module. The trust reported that from April 2017 to October 2017 MCA level 2 training had been completed by 84.1% of staff within outpatients. This was lower than the trust target of 90%.

The trust set a target of 90% for completion of MCA level 2 training. A breakdown of compliance for MCA level 2 training for medical and dental staff in surgery from April 2017 to October 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>92</td>
<td>109</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Lincoln County Hospital did not meet the trust target of 90% with 84% of medical and dental staff having completed MCA level 2 training.
A breakdown of compliance for MCA level 2 training for qualified nursing and health visiting staff in surgery from April 2017 to October 2017 is shown below:

**Lincoln County Hospital – Qualified nursing & health visiting staff (Qualified nurses)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>210</td>
<td>260</td>
<td>81%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Lincoln County Hospital did not meet the trust target of 90% with 81% of qualified nursing & health visiting staff having completed MCA level 2 training.

Nursing and medical staff demonstrated to us an understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and had access to the trust policy and procedures for consent. Six patients we spoke with confirmed they had been given sufficient information to help them to decide to proceed with investigations and surgical procedures. They reported they had signed a consent form prior to surgery and verbally consented to blood tests and scans. Where patients' had capacity to consent, consent was sought in accordance with legal requirements and we saw staff recorded discussions with patients about risks, benefits and options about their care and treatment. We observed staff asking for consent both verbally and in writing. On checking a further five patient records (patients with capacity to consent), we saw copies of signed consent forms, which had been completed appropriately.

Consent form four (a form used for the consenting of patients who lack capacity) was consistently completed in three out of four patient records (patients without capacity to consent). The Mental Capacity Assessment (MCA) had been completed. This meant the patients had mostly been consented correctly. Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguard training and updates were included as part of safeguarding training. During our 2016 inspection most of the staff (except on Shuttleworth Ward) we spoke with had limited knowledge concerning MCA assessments. During this inspection all staff we spoke with were able to tell us about MCA assessments and the safeguarding team at the hospital.
Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family Test (FFT) response rate for surgery at United Lincolnshire Hospitals NHS Trust was 27% which was similar to the England average of 29% from December 2016 to November 2017.

A breakdown of response rates by site can be viewed below:

Friends and family test response rate at United Lincolnshire Hospitals NHS Trust, by site.

![Graph showing FFT response rates by site]

The percentage of patients that would recommend the hospital to friends and family is split by ward below:

(Source: NHS England Friends and Family Test)

The Friends and Family Test (FFT) is a single question survey, which asks patients whether they would recommend the NHS service, they have received to friends and family who need similar treatment or care. The overall FFT response rate for surgery was 25% for the period December 2016 to November 2017 with response rates varying between 21% and 38% across the surgical wards. The England average response rate for the same period was 29%. Each month 60-96% of respondents would recommend the surgical wards and departments at Lincoln County Hospital. All surgical wards at LCH displayed FFT information including 'you said, we did' information.
Ward managers were aware of the low response rates and were giving out more cards unfortunately they were not always completed and they felt that many of their patients were not able to take part in a telephone or text response.

We spoke with 26 patients and three relatives during this inspection. Four patients on the surgical assessment unit told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff. They also commented that they had been given enough information about their treatment plan. Patients on Hatton, Shuttleworth and Neustadt-Welton Wards told us, “nurses always answer the buzzer quickly”, “been brilliant”, “feel very safe” and “lovely people”. We observed staff on Greetwell, Clayton and SEAU maintain patients’ privacy and dignity by using the curtains prior to any procedures and discussions. They asked patients how they preferred to be addressed and explained procedures. All patients we spoke with were happy that privacy and dignity was maintained. A relative SEAU told us they had been called in as an emergency and the care and understanding of all the staff was “excellent”. They felt their relative was “in safe hands” and could not praise staff enough for keeping them informed.

During our inspection, we observed staff were kind, had a caring, compassionate attitude, and had positive relationships with patients using the service and those close to them. Staff spent time talking to patients. During lunchtime, we observed patients being provided with support. We observed staff were kind and respectful when supporting patients to eat and drink taking time to enable patients to eat their meals. During a lunchtime observation on Neustadt- Welton Ward, we observed the kind and supportive interaction of a nurse assisting a patient out of bed for them to sit more comfortably for their meal. The nurse ensured the meal was kept warm whilst assisting the patient. Similarly on Hatton Ward nurses were assisting patients cutting up their food.

We observed physiotherapy and occupational therapy staff assisting with patient therapy sessions encouraging mobilisation and self-care activities

**Emotional support**

We observed staff caring for a distressed relative on Hatton Ward, offering them support and re-assurance as the patient was upset having been admitted to hospital as an emergency. All 20 patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.

There was a trust wide chaplaincy service; we saw this advertised on notice boards within the wards. The chaplaincy team provided an on call service, which was also available out of hours. They provided support and assistance to patients to contact local spiritual or religious priest or ministers. We saw a priest visiting one ward at the request of a patient.

Patients and staff had access to clinical nurse specialists across the surgical areas. For example, we saw that there were specialist nurses for colorectal, stoma, breast care and the acute pain team. Clinical nurse specialists supported patients to manage their own health, care and wellbeing and to maximise their independence. We saw the colorectal nurse specialist advising a patient who had a newly formed stoma. A stoma is an artificial opening made from the bowel onto the tummy for certain bowel conditions.

Patients informed us staff tried their best to make the hospital environment as normal as possible and we observed a number of patients had personal belongings with them such as photographs and items from home if they helped a patient living with dementia.

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

A patient on Hatton Ward told us the staff were “fantastic” and that she felt involved throughout with her care and had special praise for one nurse that she said was “outstanding” after she had helped sought out a problem for her.
The trust had good results for the Care Quality Commission (CQC) inpatient survey 2016 which looked at patient experiences across different hospital departments. This survey looked at the experiences of 77,850 people who received care at an NHS hospital in July 2016. Between August 2016 and January 2017, a questionnaire was sent to 1250 recent inpatients at this trust.

Responses were received from 526 patients at United Lincolnshire NHS Trust. In all 11 questions, they were rated about the same as other trusts. There was one area the trust were considered worse than other trusts, these were, patients' views – patients felt they were not asked to give their views of the quality of the care provided. This was also worse than other trusts during our previous inspection. However, all patients we spoke with were without exception very happy that their views and concerns were taken into consideration.

Patients told us they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them, doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.

We spoke with three relatives, they all told us they had been kept informed of the patients’ progress and staff were approachable if they needed to ask any questions. Staff on the wards were aware of patient confidentiality and told us they always checked with the patient if they were unsure of who was making the request for information. All members of the multidisciplinary team explained care and treatment in a way that could be understood. We observed a member of staff speaking with a relative to explain about the patient’s care. We observed ward receptionists helping relatives with information requests and taking phone messages to patients from relatives.

We saw information on all surgical wards which recognised that families and trusted friends had an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. The trust had introduced the carer’s badge, which enabled any family members and trusted friends to be involved in the care of their loved ones. The carers badge encouraged carer involvement, particularly for patients with additional needs. One carer told us they were treated very well and were fully involved in their relatives care. They were supported to assist with personal care, as this was what the patient preferred.

We observed good interactions between staff and patients in the surgical admissions lounge, and the recovery suite of the main theatres. Staff spoke in a quiet calm manner to patients explaining what was happening to them and what was going to happen next. Information about surgery was shared with patients, and patients were able to ask questions. Patients and relatives said they were kept informed and felt involved in the treatment received.

**Is the service responsive?**

### Service delivery to meet the needs of local people

#### Average length of stay

**Trust Level – elective patients**

From October 2016 to September 2017, the average length of stay for all elective patients at the trust was 2.6 days, which was lower than expected compared to the England average of 3.3 days.

When split by specialty the average length of stay for all three of the most common specialties (based on count of elective activity) at the trust was similar to the England average.
Elective Average Length of Stay – Trust Level

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

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 5.2 days, which was similar to expected when compared to the England average of 5.0 days.

When split by specialty the average length of stay for two of the three most common specialties (based on count of non-elective activity) at the trust was similar to the England average. These were General Surgery and Urology. The average length of stay for non-elective Trauma and Orthopaedics patients was 7.3 days which was lower than the England average of 8.9 days.

Non-Elective Average Length of Stay – Trust Level

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

Lincoln County Hospital - elective patients

From October 2016 to September 2017 the average length of stay for all elective patients at Lincoln County Hospital was 2.6 days, which was lower than the England average of 3.3 days.

When split by specialty the average length of stay for two of the three most common specialties (based on count of elective activity) at the hospital was similar to the England average. These were Trauma and Orthopaedics and Urology. However, the average length of stay for elective General Surgery patients was 4.8 days which was higher than the England average of 3.3 days.
Elective Average Length of Stay - Lincoln County Hospital

![Bar chart showing Elective Average Length of Stay]

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

Lincoln County Hospital - non-elective patients

The average length of stay for all non-elective patients at Lincoln County Hospital was 5.0 days, which was as expected compared to the England average of 5.0 days.

When split by specialty the average length of stay for two of the three most common specialties (based on count of non-elective activity) at the hospital was similar to the England average. These were General Surgery and Urology. The average length of stay for non-elective Trauma and Orthopaedics patients was 7.4 days which was lower than the England average of 8.9 days.

Non-Elective Average Length of Stay - Lincoln County Hospital

![Bar chart showing Non-Elective Average Length of Stay]

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

The service understood the different needs of the patients it served and acted on these to plan, design and deliver services. During our 2016 inspection services included a surgical emergency admission unit triage area. Patients referred from their general practitioner (GP) could be reviewed and treated on occasions without need for admission to hospital. This service had expanded to include some emergency department admissions an advanced nurse practitioner (ANP) was available from 8am to 5 pm to assist in the reduction of unnecessary patient admissions. Such was the success of this programme the trust was set to expand the service with a business proposal for the alteration of a bay on the ward. This would provide a dedicated space for six patients with two dedicated ANPs. Improving the safety of the patients with improved observation in a dedicated area and reducing hospital admission for patients requiring diagnostic scans that may otherwise have been admitted. We spoke with the consultant surgical lead after his ward round, three patients had been admitted the night before after 5pm that could have avoided admission if this service was fully operational.

Implementation of eight level one beds (high dependency) on Hatton Ward had also had an impact on meeting the needs of local people. Clinical staff we spoke with told us that the use of these beds for patients of a higher dependency post theatre had reduced the number of cancellations for theatres due to having a bed available when previously this would have been booked on the Intensive care. Research and audit was ongoing. However, early evidence we saw highlighted a reduction in length of stay for these patients. This was considered to be linked to the patient’s perception of staying in a ward rather than an
intensive care unit. For example patients on a ward are thought not to suffer the debilitation and dependency created by an admission to intensive care for level one observation.

The trust engaged with internal and external stakeholders including patients, governors, members, partners and staff to plan services. For example, the trust engaged patients and members of the community to join locality forums to help shape the future of the services provided. Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally.

In planning services, the surgical business unit appointed a number of specialist nurses and clinical educators across the site to support ward provision and to meet the needs of patients requiring specialist care. For example, colorectal nurse specialists ran a patient experience event each year during to address any negative concerns patients had and celebrate any positive findings. Orthopaedic nurse specialists ran weekly hip and knee classes which included physiotherapists, occupational therapists, medical and nursing staff. These were aimed at reducing length of stay by ensuring the patients were aware of the reasons for mobilising earlier post operatively.

Patients being seen in outpatients or the emergency department needing specialist facial cancer surgery requiring extensive reconstruction were referred to a nearby NHS trust for their surgical procedure. A joint cancer MDT meeting was held at the receiving trust and involved an oncology and head and neck surgeon from Lincoln County and the oncology-head and neck surgeons from the nearby trust. This meeting ensured patients’, initially seen in Lincoln, were surgically managed in the nearby trust and then safely transferred back to Lincoln for further out patient and postoperative follow up. The urology team also had joint MDT links with other trusts to ensure that patients were transferred in a timely manner for further assessment or specialist surgical procedures.

Meeting people’s individual needs

All elective patients were seen for pre assessments. When attending the preoperative clinics all patients were given an information pack to take home with them which included pre-surgery high calorie drinks, information on quitting smoking (if requested) and advice specific to the type of anaesthesia and surgery they would be receiving. This was to ensure patients were as fit as possible prior to the surgery. We spoke with patients on the surgical wards who were able to confirm this information was provided and that the information was useful. Packs also contained telephone numbers for further advice.

Staff on the surgical assessment lounge worked closely with the pre assessment clinic staff in order to identify and care for patients living with a learning disability or dementia. Staff used pictorial risk assessments and care plans. There was an enhanced care risk tool which aided the delivery of care to patients in need of additional support for those patients at higher risk of falls or dementia. The tool assessed and graded patients as either red (high risk), amber (some supervision: needing 15 minute checks) and green (low risk) needing less observations. Staff told us it was possible for relatives to stay overnight; the patient would be nursed in a single room where a foldaway bed was available. This was a common occurrence for patients living with dementia or learning disabilities when relatives or carers stayed overnight in order to reduce anxiety and disorientation in the patient.

There were no mixed gender breaches as bays were adjusted to meet the demand for male and female patients.

Between December 2017 and March 2018 data provided by the trust showed there was one patient transferred from ICU to a surgical ward during the night.

The service had out of hour’s emergency arrangements with the mental health team which was known by all staff we spoke with. There was also 24/7 access to the advanced mental health nurse practitioners and a psychiatrist.

The trust offered pastoral, spiritual and religious support to patients, relatives and staff. A 24/7 on-call service was provided and where possible a representative of the patient's own faith attended. The hospital
had a chapel and prayer room. Patients were aware of the prayer rooms available to them. All patients were asked about their religious and spiritual preferences on admission and we saw evidence of completed nursing care documents to support this. Nursing care documents also contained an ‘about me’ section. This section captured general information about the patient such as sleep and rest patterns, communication and personal hygiene and allowed the patient to express any personal preferences. This document was especially useful in caring for patients living with dementia.

The trust provided an interpretation and translation service available 24 hours a day, seven days a week through a contracted supplier. This service included face-to-face interpreting, telephone interpreting and written translation. Information could be translated into different languages on request. Staff we spoke with were aware of this service and the policy.

During our 2016 inspection, we noted very limited signage in different languages to enable non-English speaking patients and visitors to find their way around the hospital site. This had not changed however we did see leaflets in different languages advising patients of where they could get further assistance.

The patient record identified diabetic patients. The trust had a team of diabetic nurse specialists who received daily reports of diabetic patients admitted to the hospital. An inpatient nursing assessment document was completed for all admissions. This included a section on nutrition and hydration. This was mostly completed in all of the 20 assessment documents we reviewed and stated dietary requirements for example ‘diabetic’ or ‘vegetarian’, whether any special utensils were required and whether the patient had any difficulties swallowing. However, patient food preferences were not always documented in the ‘identify actions’ section.

There were protected meal times in place on surgical wards, which ensured staff had dedicated time to help patients. All ward clinical and administrative staff assisted with giving out meals to ensure that staff able to assist patients were available whilst the food was still warm. Patients requiring assistance with eating and drinking were identified using magnetic pictures on the white boards behind their bed. This ensured they were assisted accordingly. We saw patients being asked if they required any help with their meals. For example, cutting food up or changing position in bed if unable to sit out to eat. Fourteen out of 15 patients we specifically asked about food told us they were satisfied with the food and two said that it was “always hot and tasty” and there was “lots of choice” Food was available on the wards throughout the 24-hour period. A range of diet choices was available including vegetarian, gluten free, kosher and halal. We saw housekeeping and nursing staff assisting patients with menu choices.

The hospital did not have a system to identify patients who had a learning disability. However, patients with a learning disability had this recorded within the electronic patient record along with their admitting diagnosis. Two learning disability specialist nurses employed by a neighbouring mental health trust provided liaison support for Lincoln Hospital. One of the nurses covered Lincoln County Hospital and Louth. There was an open referral system and the nurse carried a mobile telephone so they could be alerted of the patient’s admission. Information provided by the trust indicated there was a learning disability care plan, which was instigated by the learning disability nurse specialist on referral. However we did not see this on inspection. On receipt of notification of an admission, the learning disability specialist nurse contacted the ward to discuss the patient’s individual requirements. Staff on all wards were aware of the learning disability liaison team and contacted them if they had any questions or concerns. All patients with a learning disability were initially assessed using standardised nursing and medical documentation. Some patients had their own hospital profiles, (information booklets about their daily lives and their likes and dislikes), and were asked to bring them into hospital with them. Ward and theatre staff described adjustments, which could be made for patients with learning disabilities. These included single rooms with facilities for relatives or carers to stay overnight, being first on the theatre list, relatives staying with patients until they had received their anaesthetic, being given greater time and aiming for consistent nursing staff.
The electronic patient information boards on each ward displayed key information about their care needs and included symbols indicating whether a patient had significant communication difficulties. The information displayed was discussed with patients and permission was sought.

All emergency admissions of patients over 75 years of age were screened for dementia as part of the admission process and as part of the commissioning for quality and innovation (CQUIN) for confusion assessment. There was one band four dementia practitioner at the hospital who was responsible for ensuring this information was captured. Once the information for the CQUIN had been captured this enabled the band four dementia practitioner to track where patients living with dementia were and offer support. The dementia practitioner received a daily report from information services of all patients who had been admitted to the hospital in the previous 24 hours. They attended admissions wards, visited those aged 75 years, and over in line with national screening but also held a caseload of patients living with dementia. The dementia practitioner then visited these patients to offer support, activities and enhanced care. The dementia practitioners reported to the nurse consultant for frailty and clinical educator for complex care.

Patients and carers were signposted and had access to charitable organisations for additional support and information.

All ward areas had bathroom and toilet signage in order that patients living with dementia could assist themselves to the toilet where appropriate. Wheelchair access was good throughout the hospital. Disabled toilets were located at frequent intervals and were clearly signposted.

**Access and flow**

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

From November 2016 to October 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was 56.2% compared to the England average of 69.9%. The trust performed consistently below the England average for Surgery in every month reported.

In October 2017 and November 2017 the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.
Referral to treatment rates (percentage within 18 weeks) for admitted pathways, United Lincolnshire Hospitals NHS Trust

(Source: NHS England)

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

A breakdown of referral to treatment (RTT) rates for admitted pathways in surgery, broken down by specialty is below. All six specialties at the trust performed below the England average for admitted RTT rates. The 0% RTT rate in cardiothoracic surgery relates to only one patient.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.7%</td>
<td>77.0%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>61.1%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>57.5%</td>
<td>61.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>47.3%</td>
<td>72.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>45.2%</td>
<td>64.4%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0.0%</td>
<td>83.1%</td>
</tr>
</tbody>
</table>

The trusts referral to treatment time (RTT) for surgical services continued to be lower than the England overall performance; for January 2018 the RTT was 59%. 18 week waits for general surgery (78%), breast surgery (97%), Colo-rectal surgery (86%), vascular (81%) and Trauma and orthopaedic (79%). The trust provided data for cancer waiting times which showed for quarter three 2017/18 the 14 day wait was worse than the national rate 91.2% (England 93%) and 62 day wait 70.9% (England 85%). However the 31 day wait was better than the England rate 96.8% (England 96%).

Senior managers told us they were taking steps to improve RTT. This included a review of all activity, additional outpatient sessions and ad-hoc clinics, the introduction of one-stop clinics and virtual nurse led clinics. The effectiveness of these actions were monitored through a daily report on all 12 week waits, full consultant led harm reviews weekly and designated weekly cancer RTT and risk meeting. To facilitate the time commitment required these actions had been recognised and included within consultant job plans.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has
not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

**Percentage of patients whose operation was cancelled and were not treated within 28 days - United Lincolnshire Hospitals NHS Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days.]

Over the two years, the percentage of cancelled operations at the trust showed a declining trend and since quarter 3 of 2016/17 the trust’s performance has been similar to the England average.

In the most recently reported quarter (Q2 2017/18) 3.8% of the 679 cancelled operations were not treated within 28 days which was lower than the England average of 6.8%.

**Cancelled Operations as a percentage of elective admissions - United Lincolnshire Hospitals NHS Trust**

![Graph showing cancelled operations as a percentage of elective admissions.]

Over the two years, the percentage of cancelled operations at the trust showed an upward trend, and was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

*(Source: NHS England)*

The senior managers told us, over the two months, prior to our inspection cancellations had increased. This was attributed to poor weather and staffing problems. However, readmission within 28 days had improved. Eleven theatres were available at this hospital providing emergency and elective surgery. The matron in theatre was responsible for scheduling operations. A team leader worked across the theatres every day to identify and trouble shoot problems such as capacity, overruns and staffing issues.

Senior staff told us they made decisions about whether to cancel operations the day before the operation wherever possible. Surgical operations were graded one to three; those graded three were of lower priority and more likely to be cancelled. Patients with cancer were graded one and complex operations requiring surgeons from two specialities were graded two.

The trust had an escalation policy and procedure to deal with bed availability at busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue. Bed capacity meetings
were held three times daily to monitor bed availability in the hospital; they included reviews of planned discharges to assess future bed availability.

The three site management meetings took place each day (8am, 12.30pm, and 3pm) to discuss patient flow into and out of the hospital. Representatives from senior hospital management such as matrons attended these meetings. Any available beds as well as patients who needed admission, awaiting discharge or on outlying wards were identified. From this information, the site management team decided which patients should be admitted to each ward and supported the discharge of patients to make more beds available. A ‘red to green meeting’ was also in place for each ward co-ordinator/nurse-in-charge. This meeting took place to ensure any delays within the hospital could be reviewed and expedited at the earliest opportunity. For example, waits for beds in other trusts or diagnostic waits such as ultrasound or CT.

The trust had procedures in place for surgical outliers. Outliers are patients cared for in an area outside of their speciality (for example, surgical patients on a medical ward). During our inspection, there were no surgical outliers in medical wards. However, staff on surgical wards told us during the winter they were often full with medical outliers. During our inspection, there were medical outliers on surgical wards. Staff and patients told us about delays in discharges of medical patients due to the medical reviews not taking place until the afternoon. During our 2016 inspection the trust provided an updated action plan for medical patients outlying on surgical wards whilst it identified only patients awaiting packages of care or in the recovery phase of illness should be out-lined it did not address the timeliness of ward round reviews for discharge planning. This remained the same. The Trust plan for medical outliers during the winter months by reducing the number of elective surgery cases.

The service had a Standard Operating Procedure (2017) escalation plan for using the surgical assessment lounge, (SAL), area for additional bed space when needed. The escalation plan included a risk assessment, implementation plan and monitoring mechanisms to ensure patients were safe whilst staying within the area. Staff we spoke with in SAL said the area was initially used Monday to Friday for surgical patients approaching discharge; however, since November 2017 it had been open “almost constantly”.

Learning from complaints and concerns

Posters and leaflets explaining how patients could complain were clearly visible around the hospital. Pre-operative information packs also contained information about how to make a complaint. The patient advisory and liaison service (PALS) was located in the hospital and leaflets were available for patients explaining how PALS could assist in managing complaints. Patients and visitors told us they would feel comfortable making a complaint, as nursing staff were approachable and understanding.

Summary of complaints

From October 2016 to September 2017 there were 188 complaints about surgical care. The trust took an average of 69 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 188 complaints, 130 had been closed at the time the data was provided and only 7.7% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days, when taking this target into consideration 20.0% of all of the closed complaints were closed within 50 days.

At Lincoln County Hospital there were 85 complaints. The trust took an average of 77 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 85 complaints, 63 had been closed at the time the data was provided and only 6.3% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days when taking this target into consideration, 17.5% of all of the closed complaints were closed within 50 days.
There were 13 complaints that were re-opened in the time period.

The most common themes in complaints at Lincoln County Hospital were: delay or failure in treatment or procedure (12), attitude of staff (eight), communication with the patient (eight) and discharges including arrangements and inappropriate discharges (eight).

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

Ward managers were involved in investigating complaints in their areas. All staff we spoke with knew how to deal with complaints and concerns. Nursing staff told us they would try to resolve complaints quickly and locally whenever possible. Managers for the appropriate speciality produced action plans and identified learning. Managers shared learning from complaints through team meetings, safety briefings, newsletters and emails.

We were given examples where staff had managed complaints locally and telephoned patients and their carers to discuss their complaint and the learning taken from them. We also saw boards in the ward managers' offices to collect information about compliments and complaints, which were then reported monthly to the complaints and compliments team for collation.

We saw minutes of meetings highlighting to staff that poor communication was one of the top causes for complaint. Staff were encouraged to ensure patients understood when discussing care as a result of complaints. Following recent patient feedback noise at night had been identified as a concern. As a result agreed actions included the reduction of telephone volumes, provision of soft close bins and the turning off lights. This had been cascaded to staff through the staff handover meetings.

Is the service well-led?

Leadership

Surgical services were provided at this hospital as part of the Lincoln surgical business unit. The business unit was split into four clinical directorates. These were surgery and urology, orthopaedics, theatres critical care and chronic pain and head and neck services. Since our last inspection head and neck services was now managed from the Boston Pilgrim site.

A clinical director, supported by a business manager and a head of nursing, led each clinical directorate. A band seven nurse, supported by a matron, provided local leadership on each ward. The range of experience within the senior team enabled effective leadership of the surgical service at Lincoln County Hospital. The senior team were very proud of the division and felt that with the appointment of a general manager and a new clinical director for surgery and urology would enable stabilisation and development of the service.

The majority of staff told us they felt senior staff and managers were visible, approachable and supportive and they received appropriate support to allow them to complete their jobs effectively. We met with clinical managers who felt supported and engaged with the executive team. The majority expressing how proud they were with the changes the executive team were implementing. Ward managers were able to meet weekly with the chief nurse either in person or by skype at a weekly meeting. Senior nurses we spoke with told us how useful these meetings were in keeping up to date with information cross site.

The majority of staff on wards and in theatres knew the chief executive and the chief nurse either from meeting them or from information shared through e-mails. Junior doctors told us they felt supported and there was always a senior member of staff to ask for support.
Managers we spoke with were positive about the impact of quarterly multi professional senior leadership forums introduced in 2017. The forum, chaired by the chief executive officer, had improved trust wide communication at a senior level. Additionally ward sisters had a protected ten minute ‘time to talk session’ where patient safety and current risks could be addressed with fellow managers.

Vision and strategy

The trust vision; working together to provide sustainable high quality patient-centred care for the people of Lincolnshire was underpinned by five key values; patient-centred, safety, excellence, compassion and respect. During our inspection, we met and spoke with staff in all areas who demonstrated the trust’s values by working together to provide compassionate and respectful care for patients.

The trust had a five-year strategy for all clinical services “Our Strategy 2021-Excellence in Rural Healthcare” to support the delivery of good quality patient care. The aim of this strategy was to provide consistently safe, responsive, high quality care. The 2021 strategy included the vision and values of the trust and had been developed in collaboration with staff, people who use services, and external partners. Staff understood what the strategy was, and recognised there were a number of changes occurring in the surgical departments that aligned to this and the ‘Getting it Right First Time’ initiative. The trusts vision for clinical services for the next five years was in the process of being discussed and developed before public consultation could commence. However, the trust had posted information for staff and the public on its website during November 2017.

During our meeting with the senior leadership team, we were told of plans to meet the vision and strategy for surgical care. Plans included, for example, increasing the nursing and medical establishments within surgery and the increased use of Grantham and Louth hospitals for elective and emergency pathways.

Culture

The NHS Staff Survey 2017 saw the percentage of staff (3.6 %) recommending the trust as a place to work or receive treatment as lower than the 2016 survey at 3.7%. However, most staff reported they felt respected and valued. All members of staff we spoke with were proud to work in the trust and they spoke positively about teamwork and the care they provided to patients.

The senior managers within the surgical division had high praise for their staff and recognised the challenges staff within the surgical division faced especially with the increasing demand on surgery. Most staff we spoke with felt managers at a local level were open and supportive. Staff said they were “confident discussing concerns or making suggestions to ward managers, matrons or the head of nursing for surgery”.

Staff conveyed a strong open and honest culture in all areas visited during our inspection. Staff told us they felt supported to report near misses, incidents and raise concerns to their line managers.

Staff felt supported to develop their skills and progress their careers. Many staff we spoke to had worked at the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support available from the trust. However, several staff remarked that some training courses were harder to access due to more limited funding opportunities’.

Governance

From September 2017, the trust had introduced ward accreditation as its approach to measuring the quality of care delivered to patients in the ward environment. There was a standard operating procedure in place to support the ward accreditation process with full Trust Board approval gained in June 2017. Shuttleworth and Neustadt - Welton wards had achieved amber accreditation. The staff on the wards had an action plan to address the concerns identified and would have a further accreditation review within a few weeks to ensure improvements were being made.
The governance structure had been reviewed with monthly governance meetings and quarterly trust wide meetings established. The trust had appointed additional risk management staff to work alongside departments, audit leads, matrons and the policy group to recognise and raise concerns. During our previous inspection we identified meeting minutes were varied, there were no set agendas for all specialities to follow.

During this inspection agendas and minutes were standardised and in depth. For example, we saw evidence of discussion and learning from never events and serious incidents including trends and near misses, reporting culture, morbidity and mortality and infection prevention and control for each ward area. To ensure this information was also filtered down to ward and theatre level the surgical matrons also had a ‘matron’s patch monthly quality report’. This included hot spot areas and actions taken, for example incomplete appraisals were followed up and reviewed on each area. Achievements for each area were also noted for example Hatton ward level one facility and the ambulatory initiative on the surgical emergency assessment unit.

There were four quality matrons working alongside ward sisters. The aim of these positions was to concentrate on quality of care and to support wards through the accreditation process and upskill teams with any urgent training requirements. For example, after a never event on a medical ward relating to nasogastric feeding the quality matrons were delivering competency training throughout the wards. Governance arrangements and structure had been strengthened over the past year with monthly governance meetings and quarterly trust wide meetings. Risk management staff had been appointed to work proactively with wards with audit leads, matrons and the policy group to recognise and raise concerns.

Management of risk, issues and performance

A risk register was held within surgery. The risk register was discussed at the monthly governance meetings with particular emphasis on risks scoring 15 or above. This was to ensure they were re-evaluated and any gaps in controls could be addressed. Risks included a description, controls in place to mitigate the risk and, a summary of actions taken. Senior leads and ward managers had a good knowledge of the risks contained within this register and cited housekeeper staffing, theatre equipment, capacity, cancellations, referral to treatment times (RTT), staff skill mix and bed availability. The risks reflected those identified through our discussions with the senior management team and with staff on wards. Staff we spoke with told us about the ongoing recruitment of housekeeping staff and the review of rolling replacement of theatre equipment.

From September 2017 the trust had introduced ward accreditation as its approach to measuring the quality of care delivered to patients in the ward environment using multiple methods and sources of data. In total 13 standards were monitored and a rating applied ranging from Red through to Amber and Green to eventually Blue. The ultimate aim was for all acute hospital wards across ULHT to be rated as Blue. We saw standard operating procedures were formulated to support the ward accreditation process with full Trust Board approval gained in June 2017.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident.

Information management

Service performance measures were reported and monitored. The ward managers and matrons had access to a quality and safety dashboard at all times, which displayed performance measures. The information was displayed on ward noticeboards. This meant staff and visitors could see at a glance how well wards were performing.

The trust published annual reports including for example a joint strategic needs assessment (JSNA), complaints, equality and diversity, safeguarding and infection control annual report (DIPC). These are available on the trusts public website.
Engagement

Patients were able to give feedback on their experiences through the NHS Friends and Family Test (FFT). Results from the FFT were reported and discussed at the professional forums and meetings and within wards and teams. Patient experience, including compliments and complaints, and the results of the FFT were displayed within the wards on ‘how are we doing’ notice boards.

There were patient information leaflets across the surgery wards. However, staff reported to us that patient feedback responses were reducing as many older patients did not have access to mobile phones to respond electronically. We did not see any feedback cards for patients.

The trust website and social media were used proactively across the service for patient feedback. The hospital was involved with the local area and we saw fund raising events and notices for future events to support the service.

The trust had a ‘Public engagement on 2021’ strategy to consult with the public and service users about the future of United Lincoln Hospitals NHS Trust (ULHT). The trust had contacted over 110 groups and attended 57 public meetings. The key conclusion was people would prefer services closer to home wherever possible, although people accepted specialist services where the expertise was available. The public understood the current NHS issues. Including recruitment, finance and safety.

Staff engagement

Surgical wards and operating theatres held team meetings, which were minuted. These provided relevant updates about the department, the division and the wider trust. A staff huddle took place at the beginning of each day for sharing and learning purposes. Staff told us this was a good opportunity to find out what was going on and discuss important issues. Nursing staff spoke positively of being involved in decisions and new ways of working, we saw evidence from staff meetings where local and trust developments had been discussed.

Trust staff survey 2017 results showed a score of 3.6 with one indicating staff had little engagement and five indicating highly levels of staff engagement. This was slightly down on the 2016 result of 3.75.

The chief executive sent a weekly email to all staff. This included what was happening in the trust, information about national visits, awards given and health information such as the availability of the flu vaccine.

The trust had a ‘staff engagement on 2021’ strategy. The document outlined how staff were being engaged in discussions about the future of United Lincoln Hospitals NHS Trust (ULHT). A survey of staff had established common themes for the trust to consider when developing the 2021, five year strategy. A key theme was to make better use of workforce, improving recruitment and retention of staff. Additionally the survey gave an opportunity for staff to put forward ideas which could save money or increase revenue. For example investment in renewable energy, improve clinical coding (this ensures a trust receives payment for work completed) and reduce waste. The survey indicated 64% of staff who took part knew ‘a little bit’ about the trust five year plan. However, only 18% were confident the strategy would transform ULHT.

The trust had an annual awards programme to recognise individuals or teams for hard work and contributions to good patient care. Any member of staff can nominate a colleague or team for an award. The manager on the surgical admissions lounge was chosen for an Outstanding Leader Award.

The nomination said ‘she was a visible part of the team, she always ensured staff knew their role and what was expected of them and she never left at the end of the day without speaking and thanking each individual member of the team’.

Learning, continuous improvement and innovation
The new bereavement centre at Lincoln County Hospital provided a single point of contact for relatives, to access help and advice following bereavement away from the rest of the hospital. One bereaved relative we spoke with told us the staff were very kind and helpful and advised them on “what to do next”.

All wards we visited attended the red to green meetings aimed at reducing delays and improving patient flow. The trust identified they struggled with continuing operational pressure using escalation beds for many months. Whilst escalation beds were still in use in the surgical assessment lounge, the new way of working aimed to improve patient experience by reducing in hospital waits for interventions for example CT scans or senior review. Ward staff would attend the meeting with concerns that would identify a red day and they could then be escalated to improve patient experience and avoid unnecessary delays.

The trust received national recognition for a project which recognised the role of carers in hospital. The carers’ badge came out on top and won the Rosa Parks award, which recognised best practice and innovation across the NHS. The badge was aimed at identifying carers and ensuring they were recognised as partners in care whilst a patient was in hospital.

We visited Clayton ward at Lincoln County Hospital the staff were very proud to be the first ward at United Lincolnshire Hospitals NHS Trust to be presented with Lincolnshire Carers Quality Award. Clayton Ward had been recognised following letters and cards from carers who found the team were supportive whilst their relative was on the ward and because they offer information about open visiting times for carers, free car parking and support for staff who are carers.
Outpatients

Facts and data about this service

Lincoln County Hospital is one of seven main sites delivering outpatient services across Lincolnshire to a population in excess of 720,000. From October 2016 to September 2017, the Lincoln outpatient department provided approximately 208,726 outpatient appointments.

Outpatient services were provided for a wide range of specialities, including general and specialised surgery, urology, ophthalmology, general medicine, haematology, diabetic medicine, rheumatology, dermatology and neurology.

Trust level data in this appendix will cover all three locations but data will only be split down to location level for Lincoln County Hospital and Pilgrim Hospital – the two hospitals to be inspected.

Total number of appointments compared to England

The trust had 671,404 first and follow up outpatient appointments from October 2016 to September 2017. The graph below represents how this compares to other trusts.

(Number: HES - Outpatient)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from October 2016 to September 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>462,768</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>306,322</td>
</tr>
<tr>
<td>Grantham &amp; District Hospital</td>
<td>130,555</td>
</tr>
<tr>
<td>County Hospital Louth</td>
<td>35,793</td>
</tr>
<tr>
<td>Johnson Hospital</td>
<td>29,976</td>
</tr>
<tr>
<td>This Trust</td>
<td>997,417</td>
</tr>
<tr>
<td>England</td>
<td>103,794,079</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
Number of appointments by specialty

The chart below shows the number of outpatient attendances for the trust by speciality from August 2016 to July 2017.

(Source: Hospital Episode Statistics)
Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from October 2016 to September 2017. The percentage of these appointments by type can be found in the chart below:

Number of appointments at United Lincolnshire Hospitals NHS Trust from October 2016 to September 2017 by site and type of appointment.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of the majority of mandatory training however some modules had a higher target which can be seen in the table below.

A breakdown of compliance for mandatory training courses from April 2017 to October 2017 for medical/dental staff in outpatients is shown below:
Lincoln County Hospital – medical / dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>26</td>
<td>20</td>
<td>77</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>26</td>
<td>20</td>
<td>77</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>26</td>
<td>19</td>
<td>73</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>26</td>
<td>19</td>
<td>73</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>26</td>
<td>18</td>
<td>69</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling – Object</td>
<td>26</td>
<td>18</td>
<td>69</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>26</td>
<td>17</td>
<td>65</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>26</td>
<td>17</td>
<td>65</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>26</td>
<td>14</td>
<td>54</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>26</td>
<td>13</td>
<td>50</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>26</td>
<td>11</td>
<td>42</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>0</td>
<td>1</td>
<td>N/A</td>
<td>90</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The trust’s target was not met in any of the mandatory training modules for medical and dental staff at both Lincoln County Hospital and Pilgrim Hospital. Note that due to the small number of staff eligible for the training (particularly at Pilgrim Hospital) the figures can be skewed. For example, at Pilgrim Hospital all staff must have completed a training module for the trust target to be met.

Managers told us this was due to training rates for medical staff being reported within the individual directorates.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and health visiting staff in outpatients is shown below:

Lincoln County Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - Object</td>
<td>90</td>
<td>89</td>
<td>99</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>90</td>
<td>88</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>90</td>
<td>88</td>
<td>98</td>
<td>95</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>90</td>
<td>88</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>90</td>
<td>88</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>90</td>
<td>88</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>90</td>
<td>86</td>
<td>96</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>90</td>
<td>82</td>
<td>91</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>90</td>
<td>77</td>
<td>86</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>90</td>
<td>71</td>
<td>79</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>90</td>
<td>68</td>
<td>76</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>0</td>
<td>33</td>
<td>N/A</td>
<td>90</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>0</td>
<td>1</td>
<td>N/A</td>
<td>TBC</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Evidence appendix United Lincolnshire Hospitals NHS Trust
The trust’s target was not met for five out of the 11 eligible training modules for qualified nursing and health visiting staff at Lincoln Hospital. The lowest training compliance was for major incident awareness training (75.6%).

(Source: Routine Provider Information Request (RPIR) – Training)

Staff told us, during busy times they struggled to complete their mandatory training, which was a mixture of face-to-face training and electronic learning packages. Managers tried to support staff with allocated time to complete online training. All staff we spoke with, including therapy staff, said they had completed their mandatory training and were up to date.

Locally managers maintained oversight of training records through monthly reports. This ensured staff were booked onto training and received prompts to complete online learning.

Safeguarding

Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff through mandatory training.

The Director of Nursing was the executive lead for safeguarding trust wide. Policies, procedures, protocols and frameworks relating to safeguarding, including female genital mutilation, were in place and staff told us they were easily accessible.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training on how to recognise and report abuse and they knew their responsibilities around putting this into practice. Staff gave examples of when they had raised safeguarding concerns, for example if patients attended with unexplained bruising or injuries.

Staff had policies and procedures in place for extra observation and supervision of treatment of vulnerable adults or children. Staff used chaperones, parents, relatives and carers to support and observe patients.

Safeguarding training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training from April 2017 to October 2017 for medical/dental staff in outpatients is shown below:

Lincoln County Hospital – medical / dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>26</td>
<td>17</td>
<td>65</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>26</td>
<td>17</td>
<td>65</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>26</td>
<td>16</td>
<td>62</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>26</td>
<td>16</td>
<td>62</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>15</td>
<td>9</td>
<td>60</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>
The 90% target was not met for any of the safeguarding training modules for which medical and dental staff were eligible at both Lincoln County Hospital and Pilgrim Hospital.

A breakdown of compliance for safeguarding training from April 2017 to October 2017 for qualified nursing and health visiting staff in outpatients is shown below:

Lincoln County Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>90</td>
<td>90</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>90</td>
<td>90</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>90</td>
<td>88</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>90</td>
<td>88</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>45</td>
<td>41</td>
<td>91</td>
<td>90</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all safeguarding training modules for which qualified nursing and health visiting staff were eligible at both Lincoln County Hospital and Pilgrim Hospital.

(Source: Routine Provider Information Request (RPIR) – Training)

During our inspection, staff we spoke with confirmed those working with children had received safeguarding level three training. Within ophthalmology, training records reviewed on site confirmed 87% of appropriate staff had received safeguarding mandatory training (level three). This was close to the trust target of 90%.

**Cleanliness, infection control and hygiene**

There were reliable systems in place to prevent and protect people from a healthcare-associated infection.

The trust had a dedicated infection prevention team working across all three sites. The chief nurse held the role of director of infection prevention and control and a consultant was the lead infection prevention doctor.

Staff had access to a range of infection prevention and control policies, procedures and guidelines. These were available on the trust’s Intranet site. We saw staff adhere to these policies in relation to hand hygiene and infection control. For example, we saw staff observed the ‘bare below the elbow’ rule and did not wear watches or jewellery in clinical areas. Staff used personal and protective equipment (PPE) when providing treatment care such as aprons and gloves.

Information displayed in the clinics reminded staff of their responsibilities to adhere to the dress code policies.

The majority of clinics we visited were visibly clean and we observed hand sanitiser available near entrances and in waiting areas for staff, patients and visitors to use. We observed staff adhering to the five moments for hand hygiene (World Health Organisation). These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.
The daily ward assurance process included the prompt: ‘patients are being protected against infection’. This reviewed PPE, adherence to uniform policy and hand washing observation.

The trust had a policy for changing curtains regularly or when visibly soiled. Most curtains we checked were visibly clean and changed in line with trust policy. However, we saw some curtains were not disposable and did not appear to have been changed for some time, for example within the phlebotomy clinic. We could not determine exactly how long because there were no dates for replacement displayed on them. This presented a possible infection control risk to staff and patients.

Completed records identified daily flushing of taps was performed (during opening times), to reduce the risk of cross contamination by Legionella.

Environment and equipment

The outpatient clinics were located on two floors, with access by stairs or lifts. There was a central outpatient reception desk, which was located on the upper floor. This was located adjacent to a large visitor refreshment area.

Most clinics we visited appeared calm with sufficient seating to accommodate patients and companions. We saw information boards updated for waiting times and staff readily available to support patients. An exception to this was the haematology clinic that had not changed since the CQC visit in 2016. The waiting area was cramped with an overspill into the access corridor. This was in part due to the shared facilities with the busy phlebotomy service. On the day of our visit, 168 patients had attended the service by 2pm. Funding for large scale refurbishments was limited and prioritised for completion of essential fire safety work.

Outpatient services had arrangements and procedures for managing waste and clinical specimens. We observed staff managing specimens and clinical waste appropriately and safely in line with trust policy. We saw sharps bins labelled, initialled and dated in accordance with national guidance. Staff disposed of clinical waste in dedicated colour coded bags in the dirty utility. Clean and dirty utility rooms were separate and locked with keypad entry (clinic four).

Staff had access to resuscitation equipment. Resuscitation trolleys were available within the clinic areas. Training received training on the use of emergency equipment, for example, the automated external defibrillator (AED) as part of basic life support training. An AED is a portable device checking the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm.

We checked two resuscitation trolleys and we saw evidence staff had checked it daily. The trolley had appropriate equipment, which was all in date. A daily assurance log used in the laser ophthalmology clinic since April 2017 had improved completion of daily tasks and equipment checks.

We saw the room containing laser equipment was labelled appropriately with hazard notices and protection advice. The room was locked when not in use.

We saw evidence of up to date health and safety risk assessments in clinic areas, including a ligature assessments.

The service had procedures in place to check, test and service equipment. We checked 12 pieces of equipment. All equipment in use had been tested and checked in accordance with trust policies. We observed staff cleaning and wiping down equipment before, after and in-between clinics. In the
event of broken equipment managers had to await approval before repair. This prevented the procedures from taking place.

The trust had identified a contract for servicing of gymnasium equipment identified as an issue in the inspection in 2016.

Assessing and responding to patient risk

When we inspected the outpatient department in October 2016, we found there was no system in place to monitor and manage the risk to patients on the waiting list. This meant the hospital was failing to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.

Since our previous inspection, the trust had introduced a process to review the harm that may have been caused to some patients as a result of longer waiting times. We reviewed the outpatient harm review standard operating procedure (SOP) which specified the criteria of patients to be reviewed. These were:

- New patient unbooked (Open Referral that is categorised as Urgent waiting over 12 weeks and six days before being booked.
- Two week wait first appointment wait over 21 days and are subsequently diagnosed with cancer
- Follow Up unbooked Partial Booking Waiting List (PBWL) going over one Day - Time Critical
- 52 week waiters on an Incomplete Pathway

In addition, the trust had added mandatory actions for the clinicians to complete for patients with open referrals greater than 12 weeks and patients who had been allocated time critical appointments that were overdue. Staff performed these at the clinic appointment and reported on the e-outcomes report forms. Clinicians were also required to complete incident forms and harm review forms for all patients where the level of harm was identified to be low, moderate or severe, which would then be reviewed at governance meetings. At present the harm review process was performed in retrospect and would not prevent harm.

We saw copies of letters sent to patients on the waiting list who were awaiting urgent appointments following their initial referral by their GP. Patients waiting over 12 weeks and over 24 weeks were sent letters to apologise for the delay. The letter asked patients to contact the trust’s Patient Advisory and Liaison Service (PALS) or their own GP if they believed their condition had deteriorated.

During this inspection, we saw all patients records outcomes were recorded electronically, which was the responsibility of the lead clinician. Data provided by the trust showed, as of March 2018, there were 6044 incomplete outcomes trust wide (better than 8108 in 2016). The majority of the missing outcomes were for clinics held in February 2018 (3,800). However there were 412 missing outcomes up to January 2018, the oldest dated back to clinics held in March 2017 (i.e. 12 months overdue). The top three specialities for missing outcomes was Dermatology (1042), ophthalmology (520) and urology (497). This meant patients might be at risk of staff not taking appropriate action regarding the care and treatment they needed. We did however note at the time of our inspection the trust had to deal with severe weather conditions (snow 28th Feb – 2nd March) this meant the Trust had a reduced workforce and increased cancelled clinics (over 3000 patients were cancelled) these increased the missing outcome position as they sat on clinics still showing on the PAS system. This trust were and we working to clear this backlog.
Managers audited patient outcome results to identify which patients did not have an outcome recorded. We reviewed minutes of the trust wide RTT Delivery and Recovery meeting February 2018, where missing outcomes were discussed and highlighted by speciality. Service leads told us it was the clinician’s responsibility to ensure patient outcomes were recorded, and the clinical specialties were held to account for missing outcomes. We did not see actions to address these, although individuals were identified to action each speciality. We were not assured this was a robust process in view of the number of outcomes that were missing and the length of time some had been outstanding.

Staff did not routinely use early warning scores within outpatient areas. However, outpatient services had clear processes for admitting clinically unwell patients to hospital. If a patient became unwell, during their attendance, staff escalated to senior nurses and consultants were on hand to treat deteriorating patients immediately. Consultants could also contact the bed management team to arrange admission. In addition, staff could call for help using an emergency number (2222) which alerted a specialist team trained in the management of seriously ill patients.

All clinic rooms had emergency call bells, which were checked daily.

A daily huddle, or ‘time to talk’ had improved staff awareness of current issues on a day by day basis.

**Nurse staffing**

The trust reported their registered nursing staff numbers, as of October 2017, as shown below. For all sites there were 145.4 whole time equivalent (WTE) planned staff and 131.2 WTE staff in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>75.7</td>
<td>73.1</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>42.1</td>
<td>33.8</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing)*

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to October 2017 the trust reported a vacancy rate of 9.1% for nursing and midwifery staff in outpatients. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>11.5</td>
<td>5.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>11.5</td>
<td>15.1</td>
</tr>
</tbody>
</table>

Vacancy rates at Lincoln County Hospital were below the trust target, however at Pilgrim Hospital the vacancy rate was higher than the trust target of 11.5%.

*(Source: Routine Provider Information Request (RPIR) Vacancy)*

**Turnover rates**

This information is routinely requested within the universal provider information request
spreadsheets, to be completed within a standard template.

From November 2016 to October 2017 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 5.8% for nursing and midwifery staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust's turnover rate for nursing and midwifery staff is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>2.6</td>
<td>20.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>2.6</td>
<td>20.0</td>
<td>7.4</td>
</tr>
</tbody>
</table>

The turnover rate for both sites was within the trust’s target of 20% for an individual staff group.

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

Sickness rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017, United Lincolnshire Hospitals NHS Trust reported a sickness rate of 4.6% for nursing staff in outpatients. The trust’s target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Sickness rates for qualified nursing and health visiting staff from October 2016 to September 2017 were below the trust’s target at Lincoln County Hospital and above the target at Pilgrim Hospital.

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

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) Nursing bank agency)

The trust did not use a nursing tool to assess how many nurses should staff an outpatient clinic. There are no standards nationally for staffing levels in outpatient clinics. Services assessed the needs of each individual clinic with the speciality to determine the level of nursing support needed, based on specialty, consultant requirement and complexity of case mix.

One staff told us staff were routinely moved between clinics to fill staffing gaps, which could lengthen clinic times due to unfamiliarity. We saw signs in the fracture clinic of planned versus actual staffing levels on display.
Specialist nurse led clinics were planned and run by nursing staff such as for urology, diabetes, rheumatology.

**Medical staffing**

The trust reported their medical and dental staff numbers as below as of October 2017. For all sites there were 26.3 WTE planned staff and 20.7 WTE staff in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE planned Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>22.9</td>
<td>18.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>1.3</td>
<td>0.4</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing)*

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As of October 2017 the trust reported a vacancy rate of 25.2% for medical and dental staff in outpatients. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>12.0</td>
<td>24.7</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>12.0</td>
<td>69.5</td>
</tr>
</tbody>
</table>

Vacancy rates at both Lincoln County Hospital and Pilgrim Hospital were higher than the trust target of 12.0%. The very high vacancy rate at Pilgrim Hospital is accounted for by the small numbers of staff at the hospital (there were 4.8 WTE vacancies at the hospital).

*(Source: Routine Provider Information Request (RPIR) Vacancy)*

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to October 2017 United Lincolnshire Hospital reported an annual turnover rate of 18.2% for medical and dental staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>2.8</td>
<td>20.0</td>
<td>20.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>0</td>
<td>20.0</td>
<td>0</td>
</tr>
</tbody>
</table>

The turnover rate for Pilgrim Hospital was below the trust’s voluntary target. Lincoln Hospital did not meet the trust’s target of a turnover rate of less than 20% for an individual staff group.

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

We saw evidence of staff throughout the hospital supporting outpatient’s clinics due to staff absence. Locum and agency staff were employed for each speciality and received localised inductions including in outpatient clinics.
Sickness rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017 United Lincolnshire Hospital reported a sickness rate of 0.2% for medical and dental staff in outpatients. The trust’s target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Sickness rates for medical and dental staff from October 2016 to September 2017 were below the trust’s target at both hospital sites.

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

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) Medical agency locum)

Therapist staffing

There were 294 whole time equivalent staff working trust wide within the therapy service, who provided outpatient, in-patient and community home based services.

Service leads described a high vacancy rate of 14%. In an attempt to address this, a practice based learning programme was in place with a regional university. The initial cohort was 15 occupational therapists and 15 physiotherapists, with 15 the following year. The programme was described by the manager as a trailblazer for a degree apprenticeship for therapy services.

Records

We reviewed four sets of paper patient records. Some of these were large and aged, however leaves were secure within the folder. All records contained the necessary information needed to plan and conduct care and treatment. Records contained care plans including any mental health or disability needs. Records contained letters to GPs and other relevant care providers. Staff we spoke with on inspection and at focus groups complained notes were large and tattered.

The majority of medical records used within the trust were in paper format. Some records were available on-line, such as test results, diagnostic images, referral and clinic letters, however the main source of medical records were in hard copy, which were requested for clinic appointments. We saw staff used an electronic ordering and tracking system. We were told of future plans to move to electronic records, but this was unlikely to be within the next five years, because of other financial commitments.
Improvement plans had been developed for improving availability, condition and storage of health records. This involved a merger of records teams and restricted access to the department for medical secretaries. A recent re-launch of the guidance around storage of health records had improved staff awareness. Staff described an improvement in the service and access to patient records for clinics. Data demonstrated records were available for 98% of clinic appointments. Staff in medical records wore uniforms to increase visibility and support for clinical staff.

We reviewed a copy of the trust’s Quality and Safety Improvement Plan, which identified approximately 180,000 records across the trust that required merging or repair. The trust had created a ‘merge and repair’ project team. This was an additional 13 whole time equivalent staff employed for one year to repair damaged files and merge temporary and permanent notes. The trust had set a target of 23,500 notes to be repaired within the year from May 2017, and data provided by the trust during the course of our inspection showed that they were on target to exceed this trajectory. Service leads told us a business case was to be submitted for an additional two members of staff to continue the work when then ‘merge and repair’ project was completed.

The trust had a standard operating procedure (SOP) for the minimum data that was required in temporary notes. All notes were required to have as a minimum a copy of the referral letter, patient identifiable labels, blank history sheets, test results and the last clinic letter if applicable. We saw clinic staff had access to such essential information on-line.

Staff we spoke with gave mixed views on the improvements made, although many had been involved in the improvements focus groups. Some described a process of merging the smaller notes to meet targets.

We saw that most records were stored in a way that protected patient confidentiality. Patient records were stored in locked trolleys or within offices and manned reception areas, although we did see open trolleys behind unmanned reception desks for short periods.

**Medicines**

In December 2017, the trust identified that there was a lack of secure storage for medicines used in the outpatient consulting rooms. This was added to the risk register and at the time of our inspection secure medicines cabinets had been ordered for all consulting rooms trust wide. We saw control measures had been introduced in the interim to reduce the risk of unauthorised access to medicines.

Staff stored medicines in locked cupboards or fridges. Staff checked cupboards and fridges daily and recorded fridge temperatures. There were no controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001) stored within the general outpatient’s area, however we did see controlled drugs stored within other specialist outpatient areas, for example maxillofacial surgery. We saw the CDs were stored appropriately in a locked cupboard and the keys held separately from the main keys. Prescription pads were not in use in the departments due to the close proximity of an independent pharmacy on site.

Drug boxes were awaiting installation in the ophthalmology clinic for use in each room. This would improve access to the drugs, reduce risk of unattended drugs, (an issue identified by the trust pharmacy team), and improve patient treatments.
We asked five patients about their medicines, all of them said staff told them about any new medicines in a way they understood. We observed during clinics medical and nursing staff provided advice to patients about medicines and enquire what medicines they were using.

Clinical staff discussed medicines with patients during consultations. This ensured people were receiving appropriate therapeutic drug and physical health monitoring. We saw letters to GPs included any changes in medication to support follow up.

**Incidents**

Staff had access to an incident reporting policy, which included the incident grading system and external and internal reporting requirements. Staff reported incidents, accidents and near misses through the trust’s electronic reporting system. All staff we spoke with knew the process for reporting incidents using the trust electronic reporting system.

We saw evidence of shared learning and identifying the last three incident themes on staff engagement notice boards. These included patients not receiving a cancellation letter, unavailability of mitomycin (a drug used in eye surgery) and the unavailability of medical notes. Incident reporting featured as an item on the agenda for team meetings and time to talk safety huddles to share learning.

Staff gave examples of shared learning around incidents of all levels, including learning from the wards around the awareness of thickening agents in outpatients. Also the introduction of a pressure related ulcer leaflet for children was introduced in the fracture clinic following an incident.

Managers sent out patient safety notices by email to all staff, which were also placed on notice boards.

**Never Events**

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

From January 2017 to December 2017, the trust reported no incidents classified as never events for outpatients.

*(Source: NHS Improvement - STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with two (50% of total incidents)
- Confidential information leak/information governance breach meeting SI criteria with one (25% of total incidents)
- Pressure ulcer meeting SI criteria with one (25% of total incidents)
Information for Lincoln County Hospital and Pilgrim Hospital can be found below:

**Lincoln County Hospital**

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Total incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Confidential information leak/information governance breach meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

**Pilgrim Hospital**

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Total incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

(Source: NHS Improvement - STEIS (01/12/2016 - 30/12/2017)

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

Staff could articulate an understanding of the duty of candour, the need for openness and transparency, and understood the need to inform and involve patients and families when something went wrong. Senior staff had a greater understanding of their roles in relation to the duty of candour regulation.

The trust incident reporting system included prompts and a letter for completion in the event of an incident meeting the duty of candour criteria. The trust also had a being open and honest, duty of candour policy in place, which was supported with a roll out of training.

**Safety thermometer**

The NHS safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering
harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. However, outpatient’s services did not participate in collecting data for the NHS safety thermometer.

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

Clinics displayed some safety information and performance in clinic areas including infection control, hand hygiene and patient feedback.

Is the service effective?

Evidence-based care and treatment

Guidelines were easily accessible to staff on the trust’s electronic intranet. We reviewed 12 guidelines, all but two were in date and the version highlighted with mostly up to date references in use. We saw the unstable angina guideline (STEMI) was overdue for review since February 2017 and the contrast nephropathy guideline had just passed the review date of 1st February 2018.

People’s physical, mental health and social needs were assessed and their care, treatment and support predominantly delivered in line with legislation, standards and evidence-based guidance. For example the service employed an eye clinic liaison officer in line with the Royal National Institute of Blind people national recommendations.

Outpatient services in conjunction with the clinical specialities participated in national benchmarking clinical audits such as the Sentinel Stroke National Audit programme (SSNAP), Heart Failure, the National Diabetes Inpatient Audit (NaDIA) and the national oxygen prescribing audit for patients with chronic obstructive pulmonary disease (COPD).

Occupational therapy staff worked to the Royal College of Physicians guidelines for the management of patients who had suffered a stroke. This was measured by the Sentinel Stroke National Audit programme (SSNAP), and we saw the trust had been graded ‘A’ in the previous quarter’s audit. In addition occupational therapy staff were participating in a falls avoidance project which was in line with NICE guidance.

Physiotherapists we spoke with confirmed they worked to NICE guidance and received updates on new guidance and quality standards in the process of updating, for example in relation to tracheostomy guidance.

Staff told us of plans to commence an audit of local safety standards for invasive procedures (LocSSIPS). We were told this would include a five step process with an audit of 20 random cases per consultant.

Staff working in the deep vein thrombosis (DVT) (blood clots in the legs) clinic used a recognised clinical prediction model for patients, which is considered to be good practice and in line with latest evidence.
The chronic pain management service did not meet some of the criteria as advised by the Royal College of Anaesthetists, Faculty of Pain Medicine. For example there was no psychologist input for patients or formal multi-disciplinary team meetings.

**Nutrition and hydration**

Staff made arrangements to provide food and drink to patients who were in the department for any length of time. Some clinics had water fountains and food and drink vending machines available for patients.

Where appropriate, patients had their physical and psychological needs regularly assessed and addressed, including nutrition and hydration. Dietitians and speech and language therapist regularly provided input into patient care in line with NICE guidance.

**Pain relief**

Staff assessed and managed patient’s levels throughout procedures and consultations. If required, staff accessed visual pain scores from inpatient areas.

The service provided a pain management clinic for chronic (long-term) or acute (short-term) pain. The team consisted of three chronic pain consultants, one acute pain consultant, two associate specialists, one clinical nurse specialist, two sisters, one specialist physiotherapist and two healthcare support workers.

**Patient outcomes**

Outpatient services had processes in place to record patient’s outcomes after clinic appointments. This was a combination of electronic and paper outcome forms completed by the choice and access team. We saw a backlog of 6044 incomplete outcome records trust wide. Although the service now demonstrated an awareness of the incomplete outcomes, inspectors were not assured the service appropriately monitored the outcome, or had information to show that the intended outcomes for people were being achieved.

Work was in progress to employ additional agency staff to close outstanding open pathways. Staff within the individual speciality clinics such as diabetes services and haematology clinics monitored the outcomes for their patients.

**Follow-up to new rate**

The trust monitored the number of new and follow-up appointments and reported this externally. The follow-up to new rate is a comparison of the number of follow up patients seen to the number of new patients seen, to ensure all patients are seen in a timely manner and within nationally defined targets.

From October 2016 to September 2017 the follow-up to new rate for all hospital sites was better than the England average.
Follow-up to new rate, United Lincolnshire Hospitals NHS Trust.

(Source: Hospital Episode Statistics)

Competent staff

Staff we spoke with said they had the right skills and knowledge to assess the needs, preferences and choices of the patients they saw. If staff worked within unfamiliar clinics support was offered by staff familiar with the service.

Staff in dermatology clinic reported a gap in clinical nurse specialist training caused by sickness.

Most staff had their learning needs identified through their annual appraisals and staff told us managers were keen to develop staff to take on additional responsibilities and support the service. Staff described receiving one to one meetings and support with revalidation, although the trust was not able to support financially external courses at present.

We observed there were a range of clinical nurse specialists (CNSs) employed across the outpatients service, all whom had undertaken extended training to support patients and staff.

Bank and agency staff had to provide competency assessments organised by the employing framework agency. Local inductions were organised as required by the areas at the start of every shift.

Further training was provided to support staff performing the notes merger and those using electronic records and the electronic booking systems.

Volunteers in outpatients and throughout the hospital helped direct patients to the relevant departments or clinics. These were easily identifiable with distinctive uniforms.

The volunteer staff within the department underwent a full recruitment process including disclosure and barring service checks. Each volunteer had a named supervisor and a volunteer service manager for support. The trust provided induction and training for all volunteers in line with trust policy.

Appraisal rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
The trust provided appraisal rates for staff who required an appraisal from April 2017 to October 2017. As most appraisals are carried out at the end of the financial year figures do not include all staff members. From April 2017 to October 416 staff were required to complete an appraisal with 65.1% of these having received an appraisal. This was lower than the trust target of 85%.

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

At Lincoln County Hospital 206 outpatient staff were required to complete an appraisal with 62.1% of these having received an appraisal. This did not meet the trust target of 85%. 81.6% of qualified nursing and health visiting staff had completed an appraisal and 90.0% of medical and dental staff had received an appraisal.

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

Staff we spoke with had all received or were booked to have an appraisal. Data collected from the trust whilst on inspection demonstrated 96.4% of nurses and healthcare support workers and 95% of therapy staff had received an appraisal.

**Multidisciplinary working**

Staff from all disciplines worked together as a team to assess, plan and deliver care and treatment. Doctors, nurses and other allied healthcare professionals supported each other to provide co-ordinated patient specific care. Outpatient services worked with speciality teams.
across the trust and external providers to plan and deliver care and treatment. We saw evidence all necessary staff, including those in different teams and services, were involved in assessing, planning and delivering care and treatment. Nursing staff provided positive feedback about the advice and support provided by medical staff when required.

There were multidisciplinary team (MDT) meetings held across the specialities to provide effective assessment and treatment. For example, weekly video MDT meetings with specialist staff at other sites within the trust and region for urology and respiratory specialities.

Clinical specialist nurses worked in clinics, including rheumatology, respiratory, dermatology, haematology and diabetes. These staff worked closely with consultants and specialist support services to improve patients care around specific conditions. There were also oncology and cancers specialist nurse that provided support for patients having treatment for cancer of the lung, breast, or having treatment provided by speciality such as gynaecology, urology, haematology and colorectal surgery.

Staff told us they worked alongside colleagues to support patients with multiple needs, both within the trust and externally. This included staff consulting with the hospital based, learning disability nurses, and working with community teams to support patients with best interest decisions.

**Seven-day services**

Outpatient services were provided from 8.30am to 8pm, Monday to Friday. Clinics in the main outpatient department did not routinely provide a seven day a week service. However, ad hoc Saturday morning clinics were held to reduce the number of patients waiting for an appointment. There were no long-term plans to work towards seven-day services within outpatients.

The OMF service was providing a routine 7 day service.

There were single consultant led transient ischaemic attack (TIA) clinic held every day Monday through to Saturday. A transient ischaemic attack is also known as a mini of temporary stroke and requires prompt investigation.

An on call eye casualty service was supported by the eye clinic for emergency appointments.

The plaster room clinic was open from 9am to 5pm, and the emergency department provided cover at other times.

Health records staff worked a variety of shifts to provide a 24 hour medical records service from Monday to Friday. Staff also provided a service from 06.00am to 10.00pm Saturdays and from 07.00am to 07.00pm on Sundays and bank holidays. Staff were able to access patients medical records at all other times by contacting the duty site manager.

**Health promotion**

Outpatient services supported national priorities to improve the population’s health in regards to smoking cessation, obesity, drug and alcohol dependency, dementia and cancer. Staff regularly involved patients in decisions about their own health and well-being.

The outpatient's department provided information on notice boards in each clinic area to inform patients and carers of support groups available in the local and wider area. A range of opportunities were available in individual or group settings to promote emotional and physical health needs.
The trust completed a staff influenza campaign for the 2017-18 influenza season. The flu fighters supported 10% more staff to have their flu jabs this year than last, meaning it was the 15th best performing Trust in the country, out of 245 Trusts. With an uptake of 81% of eligible frontline staff vaccinated. This achieved the Commissioning for Quality and Innovation (CQUIN) target of vaccinating 75% of frontline staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act (MCA) 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, mandatory MCA and Deprivation of Liberty Safeguards (DoLS) training compliance levels were below the trust target of 90%.

The Mental Capacity Act 2005 (MCA) is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them. Staff understood their roles and responsibilities regarding consent and decision making including the Mental Capacity Act 2005 (MCA).

Mental Capacity Act and Deprivation of Liberty training completion

Deprivation of Liberty safeguards training at the trust is completed as part of the Mental Capacity Act (MCA) level 2 training module. The trust reported that from April 2017 to October 2017 MCA level 2 training had been completed by 84.1% of staff within outpatients. This was lower than the trust target of 90%.

The trust set a target of 90% for completion of MCA level 2 training. A breakdown of compliance for MCA level 2 training for medical and dental staff in outpatients from April 2017 to October 2017 is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>26</td>
<td>16</td>
<td>62</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff at both sites had particularly low training rates. At Pilgrim Hospital only one out of three medical and dental staff had completed MCA level 2 training.

A breakdown of compliance for MCA level 2 training for qualified nursing and health visiting staff in outpatients from April 2017 to October 2017 is shown below:

Lincoln County Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>90</td>
<td>91</td>
<td>88</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust had a consent policy, which followed NHS guidelines. The Trust participated in the National Health Service Litigation authority (NHSLA) consent audit for both adults and children every six months. The trust reported these audits by speciality rather than as an outpatient’s department.

All staff told us they routinely sought patient consent to treatment and recorded this in line with trust policy. Written consent was obtained by consultants who were carrying out a procedure, in line with legislation.

Patients told us staff were good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations. This was in line with Department of Health guidance.

**Is the service caring?**

**Compassionate care**

Staff understood and respected the personal, cultural, social and religious needs of people and how these related to care needs. In all areas of the hospital there was strong involvement from the patient experience group who were active and included in decisions.

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff responded with kindness and compassion to patients in the outpatient department. We saw that staff responded sympathetically to patients in a timely and caring way despite the day to day pressures.

During our inspection we observed staff speaking to patients with respect whilst seeking consent, taking observations and delivering care. Staff introduced themselves to patients and interacted respectfully and considerately. We observed communication between staff, patients and relatives was positive with personal, cultural, social and religious needs being taken into account. Patients we spoke to told us that staff were very friendly, they had had been given very good explanations.

Staff offered patients chaperones in line with the trust pathway, particularly for intimate procedures or if patients felt vulnerable. There were posters in the clinics informing patients of their right to a chaperone. Systems were in place to protect patient’s privacy and dignity, there were signs at the reception desks asking patients to stand back so that conversations were not overheard. We also saw staff knocking on clinic room doors.

Most patients we spoke with were complimentary about the service and described staff as ‘brilliant’ ‘helpful’ and ‘approachable. Patients felt fully informed around the appointment that day, but some patients told us there was a lack of future planning and were not always aware of what to expect.

The trust obtained feedback through the Friends and Family Test (FFT), which allowed patients to give feedback on their experiences and to state whether they would recommend the service. From April to November 2017, 92% of respondents who attended the outpatients department said they were likely to recommend the service, and 4% would not recommend the service. This was lower than the England average of 94%. Staff and patients told us that after using the service patients received a request for feedback either in text messages or as an automated telephone survey.
Emotional support

Staff understood the impact of a person’s care, treatment and condition had on their wellbeing and those close to them. We saw staff supporting both patients and relatives during appointments and investigations.

We saw staff providing information leaflets to patients and observed them explaining their treatment and ongoing care. Staff used visual aids and images to explain how the treatment would work and what would happen. For example, diabetes clinic staff used plastic food to demonstrate to patients what constituted a good diet.

Patients told us they were given sufficient information to cope emotionally with their care although further information on future plans would help. We were told that if patients were distressed staff would identify how many patients were waiting ahead of them and offer to rebook the appointment if necessary.

Understanding and involvement of patients and those close to them

Patients told us staff communicated in a way that they understood their care, treatment and condition, and any care given. We heard of examples where patients moved their appointments to a different location without trouble.

Within the eye clinic patients appreciated the large print text and screens to ensure they were fully informed.

Patients we spoke with were complimentary of the sign posts to clinics and the helpfulness of volunteers throughout the hospital.

Information was displayed on notice boards in all clinic areas of support networks and advocacy services.

We saw good examples of patient involvement in their plans of care and providing a urology leaflet for other patients with the condition.

A relative we spoke with said she was ‘very grateful of the service provided, and felt her husband couldn’t get a better service if they went private.’
Is the service responsive?

Service delivery to meet the needs of local people

Mostly the services provided reflected the needs of the population served and patients had the choice of visiting any of the hospitals throughout the trust. Occasionally due to equipment or staff shortages, patients were referred to Boston for treatment. During the inspection, staff told us due to a broken fundus camera patients requiring this service would have to visit Pilgrim hospital Boston. In order to reduce waiting times, additional clinics were run at an alternative trust site, or at weekends.

The trust delivered some outpatient services in the more rural areas of the county to prevent residents having to travel to the Lincoln County Hospital site. For example, rheumatology services based at Lincoln also held clinics at Skegness, Grantham, Boston and Spalding.

The outpatient departments were signposted from the main hospital reception with coloured markings to follow. Reception staff and volunteers were situated in the main entrance to direct patients if required. Clinics were located on two floors with the majority being on the third floor. An outpatient reception desk was located on the third floor. Staff told us plans were in place to provide reception cover whenever the clinics were running.

The hospital environment had not changed significantly since the previous inspection, with many access corridors narrow and difficult to navigate. Some small-scale environmental updates had occurred and extensive changes included in the service development schedule. Infection control improvements were made to clinic six, and work planned for clinic seven, however, funding had not been available for further work.

There was a regular public bus service to the hospital and bus timetables were displayed within the department and sufficient parking for patients.

Patients told us information was provided in accessible formats before appointments.

Staff held virtual clinics for ophthalmology and performed case notes review for urology. These reduced the number of visits patients had to make to the hospital whilst receiving care.

Patients could either self-check in or see the receptionist when available. The self-check-in desks were suitable for use by sensory impaired patients. Television screens throughout the clinics identified waiting times and identified the next appointment. Staff also ensured the patients were aware of the next patient to attend.

The trust provided outpatient services for occupational therapy, physiotherapy, dietetics (diet and the effects on health) and orthotics (surgical appliances). A local community health NHS trust provided podiatry and speech and language services.

Clinical specialities provided one-stop clinics for patients requiring input from more than one service, for example breast screening, ophthalmology services or ear nose and throat when clinic nine was available.

Patients who had undergone eye surgery in the last month could self-refer to emergency eye service or have GP or optometrist referral.

The acute pain service took referrals for inpatients in Lincoln County Hospital. The service involved treatment plans for patients with difficult to manage acute and chronic pain. It also provided training for other healthcare professionals on different methods of pain management.
Staff and patients reported long delays with transport from a third party provider. Staff told us they reported any patient transport delays through their incident reporting system. Service leads were monitoring the delays and were in discussion with the external company around the concerns.

**Did not attend rate**

The service sent text messages to patients one week before the appointment to remind them of their appointment date and time and to help reduce the number of patients who did not attend.

From October 2016 to September 2017 the ‘did not attend’ rate for Lincoln County Hospital was lower than the England average and the ‘did not attend’ rate for Pilgrim Hospital was similar to the England average.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, United Lincolnshire Hospitals NHS Trust.**

![Graph showing did not attend rates over time](chart.png)

(Source: Hospital Episode Statistics)

**Meeting people’s individual needs**

The service took account of patient’s individual needs. The different outpatient departments were clearly signposted, and volunteers were situated in the main hospital entrance and offered patient’s individual assistance to find a particular clinic if required.

Information was available in accessible formats. For example, All information leaflets could be produced in large text for patients who were visually impaired.

Hearing loops were available in all outpatients’ areas and were clearly visible to assist patients with hearing difficulties

Staff told us they used telephone translation service when required for patients where English was not their first language. Staff told us it was common for sign language interpreters to be arranged for patients with hearing difficulties.

A backlog existed in clinical letters of over two weeks.
In the spring of 2017, a national access information provider audited all clinical areas of the trust, including the outpatients department, to assess accessibility for disabled patients. Accessibility information was available from both the trust’s website and the independent provider’s website. Feedback from this independent audit was being included in the trust’s estates strategy.

Health passports were completed for any vulnerable adult including those with learning disabilities, mental health needs or patients living with dementia. Dementia champions were available and could be contacted to assist and support patients and carers patient/care/supported with dementia passport.

Access and flow

People could not always access the service when they needed it. There were long waiting times for first appointments in a number of specialties (referral to treatment). However, during 2017, there was a reduction in the number of patients waiting over 12 weeks on the open referrals waiting list, reducing by 20% from 2820 at the beginning of January 2017 to 1434 at the beginning of January 2018. However, between February and March 2018, this position had deteriorated because of the reduction in additional clinic provision. Urgent care pressures had led to the cancellation of clinics and the adverse weather conditions at the end of February had a significant impact. As of 3rd April 2018 there were 2276 patients on the open referrals waiting list over 12 weeks awaiting their first appointment. This had improved slightly since the CQC inspection in 2016 (2946 patients waiting August 2016). Thirteen patients had been waiting on the incomplete pathway for over 52 weeks.

The rapid deterioration of the waiting times in February 2018, highlighted that changes had been reactive, were not embedded and demonstrating a prolonged improvement.

Clinicians performed a harm review process on these cases, with one case of moderate and one of low harm identified as a result of the prolonged delay for these patients on the incomplete pathway over 52 weeks.

The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All NHS acute hospitals are required to submit performance data to NHS England, which then publicly report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient’s appointment is booked through the NHS e-Referral Service, or when the hospital or service receives the referral letter.

Since the CQC inspection in 2016 the trust developed an outpatient improvement program. The constitutional standards and clinical directorates performance out-turn work stream focused on improving performance indicators. An initial focus of establishing accurate data improved the trust awareness of the patients waiting for new or follow up appointments on the partial booking waiting list. This highlighted 70,000 patients whose last appointment outcome indicated that further follow-up was required, but these patients weren’t on the partial booking waiting list, therefore validation of this cohort was completed in order to ensure all patients requiring a follow-up were on the partial booking waiting list.

Extensive work reduced these numbers and improved staff use of the new centralized access booking and choice system. As part of service transformation, the trust also developed a RTT delivery and recovery group.

Clinics used a mixture of partial booking and full booking processes for follow up appointments. This was dependent upon the specialty and needs of patients. Partial booking is a system which
provides patients with a target date for the next appointment. Staff contacted patients nearer the
time of the target date to arrange the exact date and time. Full booking meant staff gave patients a
date and time for their appointment and this was usually for appointments that were required
within six weeks. Partial booking reduced the risk of cancelling appointments because staff could
take into account future demand for urgent appointments or other factors such as consultant
leave.

When we inspected the outpatient service in October 2016, we found significant number of
patients were overdue appointments on the partial booking system. Following this inspection the
trust provided data relating to the number of patients waiting for a follow up appointment and we
noted some improvement. As of 19 March 2018, there were 5,964 patients on the partial booking
waiting list (compared to 7,483 in October 2016). Of these 3,333 patients had been waiting more
than 6 weeks beyond the target appointment date (compared to 3772 in October 2016). In total
there were three patients waiting more than 52 weeks, 71 patients waiting 40 to 52 weeks, 487
patients waiting 26 to 40 weeks, 1358 patients waiting 13 to 26 weeks and 1414 patients waiting
between six and 26 weeks beyond their target appointment date. In some specialities, such as
rheumatology and paediatric orthopaedics, we saw actions to address these numbers. This
included discussing with the clinical commissioning committee the diversion of patients to for care
within the community, and increasing clinic appointments in alternative settings.

The trust introduced a harm review process to review patients waiting longer than 52 weeks on an
incomplete pathway, patients with suspected cancer waiting longer than 104 days and patients
waiting more than 21 days for cancer treatment with a positive diagnosis. The retrospective review
would identify those at risk of, or who had incurred harm as a result of the long wait.

Service leads told us of changes to levels of treatment within primary care which had led to
increased referrals and subsequent longer waiting times. For example within ENT, GP surgeries
were no longer providing ear syringing and were being referred to the trust. The backlog was
being tackled by removing administration tasks from clinical nurse specialists to allow for
additional clinical sessions.

During clinics, staff informed patients of any delays to clinic times both verbally and by writing on
a white board. Patients told us that sometimes they were not kept up to date. Staff told us that
clinic cancellations were kept to a minimum, but sometimes unavoidable. Staff described the
cancellations as less with the use of the PBWL.

The trust supplied data in relation to the number of clinics cancelled. There were 29 clinics
cancelled from the 1st to the 7th of March 2018 across the trust. The majority of clinics were
cancelled with long periods of notice given, i.e. over six weeks. There were seven clinics that were
cancelled with less than six weeks’ notice and the reasons listed were ‘other’.

Data provided by the trust for the period April 2017 to February 2018 showed the average
proportion of new appointments to follow-up appointments was 1 to 1.5.
Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From November 2016 to September 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance.

From November 2016 to July 2017 the trust’s performance was between 5% to 8% worse than the England overall performance, with the percentage of patients treated within 18 weeks ranging from 82.1% and 85.0%. However there was an improvement in performance for August 2017 (87.1%) and September 2017 (85.8%) which was closer to the England overall performance (2.4% and 3.3% below the England performance respectively).

In October 2017 (and November 2017) the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, United Lincolnshire Hospitals NHS Trust.

![Graph showing RTT rates over time](image)

(Source: NHS England)

The Trust reported performance at the end of February 2018 of 86.8%, an improvement of 0.1% compared with the position in January. There were 4,860 patients incomplete on a RTT pathway over 18 weeks at the end of February. Nationally, the standard had not been achieved for 23 consecutive months, with an aggregated national performance at the end of January of 88.2%.

The three areas of highest 18 week+ incomplete pathway numbers were ENT, general surgery and trauma and orthopaedics.
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

From November 2016 to September 2017 two specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>95.3%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>94.7%</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

From November 2016 to September 2017 14 specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>52.8%</td>
<td>82.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>68.9%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>76.3%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>77.1%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>78.1%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>80.6%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>82.3%</td>
<td>89.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>84.7%</td>
<td>89.7%</td>
</tr>
<tr>
<td>Other</td>
<td>85.1%</td>
<td>91.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>85.2%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>85.7%</td>
<td>90.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>85.8%</td>
<td>95.6%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>86.4%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Urology</td>
<td>87.6%</td>
<td>88.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From November 2016 to September 2017 the trust’s referral to treatment time (RTT) for incomplete pathways has been similar to the England overall. From December 2016 to April 2017 the trust’s performance was slightly below the England performance by between 1% and 1.7%. From May to September 2017 the trust performed 0.1% to 0.7% below the England average. Over the time period the trust’s overall performance ranged from 88.1% to 89.9%

In October 2017 (and November 2017) the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.
Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, United Lincolnshire Hospitals NHS Trust.

(Source: NHS England)

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

From November 2016 to September 2017 four specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>96.1%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>95.0%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>93.0%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>86.4%</td>
<td>84.6%</td>
</tr>
</tbody>
</table>

From November 2016 to September 2017 12 specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>74.3%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>78.2%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>81.1%</td>
<td>91.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>82.7%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>84.2%</td>
<td>92.1%</td>
</tr>
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<td>Gastroenterology</td>
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<td>General Surgery</td>
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<tr>
<td>Other</td>
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<tr>
<td>Geriatric Medicine</td>
<td>96.4%</td>
<td>96.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral. For the most recent quarter (2017/18 Q2) only 87.5% of patients
were seen by a specialist within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), United Lincolnshire Hospitals NHS Trust**

(Source: NHS England – Cancer Waits)

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust is performing similar to the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). For the most recent quarter (2017/18 Q2) 96.4% of patients waited less than 31 days from diagnosis to first definitive treatment. The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), United Lincolnshire Hospitals NHS Trust**

(Source: NHS England – Cancer Waits)

**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

The trust is performing below the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. For the most recent quarter (2017/18 Q2) 69.0% of patients waited less than 62 days from urgent GP referral to definitive treatment. The performance over time is shown in the graph below. Updated dated at the time of our inspection showed performance was 75.6% for Q4.
Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, United Lincolnshire Hospitals NHS Trust

(Source: NHS England – Cancer Waits)

The trust reported cancer waiting times to the regional Quality Surveillance Group with themes identified and current outcomes. In April 2018, United Lincolnshire Hospitals highlighted a plateau in the 62 day standard and a potential deterioration due to the winter pressures. Since December 2017, the 62 day performance had stabilised following the focus on a number of improvement programmes, maintaining the rate above 75% for 3 months, this has not been achieved since 2014. The improvements included working with an external company focusing on increasing the understanding of the issues affecting performance and quality. This was included within the constitutional standards outpatients improvement plan work stream. At the time of our inspection

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff. Staff we spoke with were aware of the complaints process and procedures.

Patient Advisory and Liaison Service (PALS) leaflets were available throughout the outpatient departments giving patients details on how to make a complaint.

The complaints department sent a questionnaire to all complainants one month following their completed response. The trust asked complainants to provide feedback about the complaints process and how their complaint was handled. They used this feedback to review the current complaints process and identify where changes needed to be made to improve the service.

Most patients we spoke with felt that staff would take their complaints seriously, we heard of patients speaking directly to the nurses over transport concerns for appointments.

Summary of complaints

From October 2016 to September 2017 there were 79 complaints about outpatient care. The trust took an average of 69 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 79 complaints, 62 had been closed at the time the data was provided and only 6.5% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days. Even when taking this target into consideration still only 21.0% of all of the closed complaints were closed within 50 days.

At Lincoln County Hospital there were 31 complaints. The trust took an average of 66 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 31 complaints, 24 had been closed at the time the data was
provided and only 12.5% of these had been closed within 35 days. The trust has a further target
to close 80% complex complaints within 50 days. Even when taking this target into consideration
still only 29.2% of all of the closed complaints were closed within 50 days.

There were four complaints that were re-opened in the time period.

Many of the complaints had more than one theme. The most common themes complained about
at Lincoln County Hospital were the wait time to get an appointment (eight), the attitude of staff
(seven) and delays in diagnosis (four). There were also seven complaints that related to the
communication with the patient which split down as follows: communication of appointments
(two), conflicting information given (two), patient not listened to (one), communication regarding
condition (one), general communication with patient (one).

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

Is the service well-led?

Leadership

At the time of our last inspection in October 2016, the management of outpatients’ services was
undergoing a re-structure. At this inspection, we saw the new management structure was fully
embedded and staff appreciated the trust wide co-ordinated approach to improvement.
Administration staff from health records and the access, booking and choice team were managed
together with the outpatients nursing and reception staff as part of the pan trust Clinical Support
Services (CSS) Directorate. CSS included five clinical teams including therapies and rehabilitation,
diagnostics, radiology, breast screening and pharmacy and was also responsible for the
administrative teams for health records, access booking and choice and reception.

Reporting within the clinical support services business unit provided a single point of accountability
and single senior management team.

A Clinical Director, who was supported by four clinical leads, led the CSS business unit. In addition
there was a general manager and three matrons, some of whom had pan trust responsibilities.
The clinical director reported to the chief operating officer (COO).

The general manager was line managed by the trust’s head of operations and from whom they
would receive appraisals and monthly one to one meetings. However, during our inspection in
March 2018, we saw the general manager had not received a one to one since November 2017.
We were also concerned the general manager did not have sufficient capacity to manage the
workload. Other divisions had a quality and safety officer, who would support the general
manager; however, this role was missing from CSS. Service leads acknowledged a lack of
administrative resources within the division. They told us of plans to appoint an individual to this
role in the near future. This would be a band six, full time post.

The trust developed an outpatient matron structure (for Lincoln and Louth; Boston and Grantham)
which incorporated a substantive structure for nursing roles, this provided greater managerial
coordination and flexibility to increase and decrease service capacity within all hospital sites.

The leadership team had full appreciation of the challenges to quality and sustainability and were
actively trying to identify and implement the actions needed to address them. Each member of the
senior management team within the business unit worked on one of the seven service
improvement work streams. At present the service could not be fully assured the improvements
made were sustainable. Continued oversight was required to ensure the changes became ‘business as usual’.

Staff were mixed in their views of senior leaders. Some staff said senior leaders in the trust were not as visible as they might be. Most of the staff we spoke with knew the names of senior management, but not all knew their faces and the majority said they had not been to visit their areas. Generally, nursing staff reported clinic sisters and matrons were visible and provided a good level of support. We observed matrons out in the clinic areas during this inspection.

Staff within health records felt very supported by the new manager.

A comprehensive recovery plan was in place to manage RTT performance however, slippage had occurred, and there were risks that revised trajectories would not be met.

**Vision and strategy**

The trust developed new vision and values which were included as part of an extended communications campaign of the trust’s new 2021 strategy roadmap. This campaign was launched in late November and included engagement events, with a new visible brand for the trust, and live twitter and Facebook events with staff.

To ensure values and vision were embedded the trust also launched a staff charter and personal responsibility framework. These went hand-in-hand with their 2021 strategy and help to deliver their vision, values and ambitions.

The personal responsibility framework gave examples of the behaviors the trust would wish to see and those they would not wish to see, to help create a positive, caring working environment.

During the CQC inspection in October 2016, the trust was in the process of developing an outpatient improvement program. The program included seven work streams focusing on health records, the outpatient environment, workforce development, improvements and innovation, safety culture and engagement, constitutional standards and clinical productivity and outcomes.

The trust’s outpatients’ senior management team was working with an external consultancy company on the seven service improvement work streams identified in the outpatients' improvement program.

When we inspected in October 2016 we found progress was slow and key targets and milestones were not being met.

During this inspection, we saw the formation of an outpatient improvement committee, with the COO as executive lead. An outpatient improvement plan was devised which had seven primary work streams. These included improving health records, workforce development, improving the workplace environment for patients (estates), improvement and innovation, improving safety and culture, clinical directorates’ performance and constitutional standards. (Constitutional standards are set out in the NHS operating framework and NHS constitution and give rules and definitions for patient waiting times to be seen by consultants and for treatment.) The primary work streams were further divided into 40 sub work streams.

We were told the responsibility for the work stream relating to the environment sat with estates, with input from outpatients' senior management team. However, staff told us some of this work stream had fallen behind schedule due to the focus of trust wide estates work on fire safety programmes and measures which the trust was required to complete.
Four of the work streams had been assessed as no longer in the project stage and were now 'business as usual'. These included improving health records, workforce development, improvement and innovation and improving safety and culture. Staff described and data demonstrated an improvement in health record availability, although the workforce pressures and waiting time backlogs were not completely resolved.

During the inspection we saw senior managers still actively involved in implementation of improvements and unable to perform a greater oversight role.

Culture

Staff described an improved culture and greater teamwork in outpatient services. Open days within health records and the introduction of new uniforms had raised their profile throughout the hospital.

Throughout the service, staff were more positive about the vision and culture of outpatients, they were happier that the service was in the clinical support services directorate, and they said it raised the profile of the service in the trust and with the senior management team. Staff were more aware of the leadership team, and were happier they had one senior management team for OPD to liaise and work with.

The trust had an appointed 'Freedom to Speak up Guardian' who ensured that policies were in place and that staff knew who to contact if they had a concern. Staff we spoke with were not aware of the existence of the guardian. Staff working within outpatients and health records told us they felt listened to and felt empowered to raise concerns.

Service leads told us they were implementing dignity ambassadors and had recruited staff volunteers for the role.

Staff told us the staff charter was a useful tool to use when performing appraisals as the expectations were concrete and patient centred. Most staff we spoke with had received an appraisal in the last 12 months; however, senior managers were an exception to this.

Teams throughout outpatients were proud of the work they had done to improve outpatient services.

Governance, Management of risk, issues and performance

There were signs of improved governance arrangements, particularly within specialty specific matters and performance measures. Directorate quality and safety officers examined waiting list reports and reported to the directorate governance groups. At the time of our inspection, the outcome from these meetings was not always embedded into practice or shared with the executive team, and clinical staff were not aware of or involved in the process. This may have been due to the infancy of the process.

Some staff told us they were beginning to be able to have an awareness of their numbers evidence quality and safety.

The referral to treatment (RTT) recovery group met fortnightly and discussed harm reviews, clinical letter backlog, partial booking waiting lists, recruitment and missing patient outcomes. A recent six week programme to include monitoring and managing patient outcomes improved clinician’s awareness. The trust reported backlogs to NHSI and the local clinical commissioning group.
Due to the single business unit managers described an improved co-ordination within the governance structure and greater interaction throughout the service.

Staff told us some arrangements with partners within primary care were difficult to manage and did not always promote co-ordinated person centred care, for example within ophthalmology services. Patient centred care was promoted within services supplied by the local community trust.

Previous trajectories to address referral to treatment times and waiting list backlogs were not met and had to be readdressed in February. We were not assured the recovery plans made to address the backlog were embedded or sustainable.

The trust had systems in place for identifying risks however, plans to eliminate or reduce risks were not timely and we were not assured all the systems in place were robust. There was some alignment of senior clinical staff’s knowledge of risks and those on the risk register. Health records storage, waiting list, open referrals and new referrals were all highlighted as risks.

Following our site visit, service leads provided a copy of the pan trust risk register for CSS. The trust used a scoring system for all risks on the register and allocated a category based on the score. The highest risks scored 20, and the lowest score was one. Categories were colour coded as a visual aid for staff. However the colour coding was confusing, for some risks scoring 15 were categorised as ‘extreme’, whilst others also scoring 15 were categorised as ‘high’. Similarly some risks scoring six were marked as either ‘low’ or ‘moderate’.

Many of the risks had been on the register in excess of ten years; however, we saw recent amendments to address the action plans. For some of the ‘extreme’ risks there was little evidence of regular oversight recorded within the register and some items did not have any actions recorded to mitigate the risk. We were told that risk was discussed at the monthly governance meetings.

Of the 44 risks, 19 related in some way to health records and ten of these were classified as ‘extreme’, although it was not clear whether these risks were trust wide or location specific. Service leads told us that improving health records was one of the work streams in the outpatient improvement plan, which had been moved from project stage to ‘business as usual’. However the risk register had not been updated accordingly. Therefore we did not have assurance there was sufficient oversight of the risks recorded on the risk register. Service leads acknowledged the lack of administrative resources within the division and the quality and safety officer that was to be appointed would fulfil this role.

We saw senior staff within the clinical outpatients environment completed the ‘clinic leader assurance document’. This was a daily check by the senior nursing staff who signed to say that the department was safe, caring and well-led. This included an assessment of safe staffing, cleanliness, security and storage of medicines, availability of patient records, checking of emergency equipment and availability of chaperones. Senior staff were also required to talk to three patients about their experience, check the information boards were clear and up to date and the electronic patient calling boards were switched on. It was also a requirement that vulnerable patients had been identified and adequate provision for their care was in place for example patients with learning disabilities, living with dementia, identified safeguarding needs.

Managers within the service were aware of the impact of not only winter pressures, but also the summer and university academic year impact on the service. However, we did not see any changes in readiness for these times.

The service leads were working with an external financial company on cost saving and service improvement measures within outpatients. We saw evidence where environmental changes and
the implementation of electronic records was compromised by the financial pressures on the service.

The recent implementation of the harm review process for patients waiting for long periods on the partial booking waiting list had commenced a process of monitoring quality and impact. At present this was a retrospective review.

**Information management**

The data quality assurance group was reconvened to monitor data quality trust wide. This supported the newly implemented and upgraded electronic systems in use. Senior managers told us this gave greater awareness of patient waiting times and attendances.

The data from the electronic systems populated the scorecard measured monitored at the fortnightly meetings.

The patient outcome backlogs remained and had an impact on the quality of data staff worked with on a day-to-day basis. In addition, a delay in the writing of clinical letter had an impact on information sharing with other care providers. This was identified within one of the work streams and on the risk register.

**Engagement**

As part of the recovery and transformation plan, the trust engaged with many external stakeholders in support of specialty pathway reviews. Working groups were held with the clinical commissioning group and the trust worked alongside primary care providers to support improved performance outcomes.

Staff throughout outpatient services had been nominated for trust awards.

We had reports from staff of improved staff engagement with the trust holding focus groups around the health record changes.

Outpatient services used the NHS Friends and Family Test (FFT) to seek patient views about whether they would recommend the service to others. Data for outpatient services at the hospital for January 2018 showed 93% of patients would recommend the service to others. The number of patients who responded to the survey was 1291, which was a response rate of 9%. Patients were asked to give feedback by text. Staff told us patients did not always respond to the texts as the number was not displayed on the patient’s phone.

Patient experience group representatives had been asked to join the outpatient improvement group.

The 2017 national NHS staff survey was published at the time of our inspection. Generally, the results across the NHS were poorer in 2017 than in the previous year. However, for most of the questions in the survey, the United Lincolnshire Hospitals Trust (ULHT) score had declined more sharply. The trust identified a number of themes from the data and the free-text answers to some questions. Overall, the results demonstrate a decline in staff morale, which was not unexpected by the trust. The response rate of 45% was above the England average and encouraging for the trust that staff wanted to engage. Of the respondents, 45% would recommend ULHT as a place to work, worse than the England average of 60%.

Twelve themes were extracted from the survey with action plans around staff engagement, the new strategy and the current workforce programme.
Learning, continuous improvement and innovation

The outpatient improvement programme focused on continuous learning, improvement and innovation.

Outpatient managers implemented capacity and demand models to improve services for patients such as the 6-4-2 clinic model to reduce improve clinic utilisation and waiting times.

Advice and guidance services were available within ENT, haematology and cardiology, providing secondary care support to GP practices prior to referrals being made into the trust. This supported a more cohesive service for patients.

In addition, since late February, advice and guidance has been available within Gynaecology, Dermatology and Gastroenterology. The Neurology service will offer advice and guidance to GPs from April.

The trust as a whole was active on social media promoting services and innovations.
Pilgrim Hospital

Evidence appendix
Pilgrim Hospital
Sibsey Road
Boston
Lincolnshire
PE21 9QS

Tel: 01205 364 801
www.ulh.nhs.uk

Urgent and emergency care

Facts and data about this service

The United Lincolnshire Hospitals NHS Trust was formed in April 2000 by the merger of the three former acute hospital trusts in Lincolnshire, creating one of the largest trusts in the country. The trust serves a population of approximately 700,000 people, situated in the county of Lincolnshire.

Details of emergency departments and other Urgent and Emergency Care services

Urgent and emergency services are provided by United Lincolnshire Hospitals NHS Trust at three sites:

- Lincoln County Hospital
- Pilgrim Hospital
- Grantham and District Hospital (not being inspected in this current inspection)

Trust data in this appendix will cover all three locations but data will be split down to location level for Pilgrim Hospital.

(Source: Trust Routine Provider Information Request)

Pilgrim Hospital, Boston is a large district general hospital located on the outskirts of Boston. At Pilgrim hospital, the urgent and emergency services consist of the emergency department (ED) and an Ambulatory Emergency Care (AEC) unit.

The ED has one triage room, 10 major cubicles, three minor cubicles, one ‘fit to sit’ room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relatives room (which was also used as a mental health assessment room).

AEC is open Monday to Friday, 08:30am to 10:30pm. It has 12 spaces for assessments/treatment which consists of one male bay with three trollies and three chairs and one female bay with three trollies and three chairs. The department also has one waiting area. At the time of our inspection AEC was being used as an escalation area due to high capacity within the trust, we did not therefore, inspect this area.
Pilgrim Hospital emergency department supports the treatment of patients presenting with minor, major and traumatic injuries. Serious traumatic injury patients receive stabilisation therapy, before transfer to the major trauma centre at a neighbouring NHS trust.

**Activity and patient throughput**

**Total number of urgent and emergency care attendances at United Lincolnshire Hospitals NHS Trust compared to all acute trusts in England.**

![Graph showing attendances]

There were 156,761 attendances from April 2016 to March 2017 at United Lincolnshire Hospitals NHS Trust as indicated in the chart above.

(Source: NHS England)

From 01 April 2017 to 28 February 2018, 54,311 patients attended ED at Pilgrim hospital; of these 8,481 (16%) were 16 years or younger.
Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased from 2015/16 to 2016/17. In both years rates were higher than the England average by 3.6% and 5.1% respectively.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

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

The graph above shows data for October 2016 to September 2017.

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 90% for completion of the majority of mandatory training, however some modules had a higher target which can be seen in the table below.

A breakdown of compliance for mandatory training courses from April 2017 to October 2017 for medical/dental staff in urgent and emergency care is shown below:

Pilgrim Hospital – medical / dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>10</td>
<td>10</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>10</td>
<td>9</td>
<td>90</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>10</td>
<td>9</td>
<td>90</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>10</td>
<td>8</td>
<td>80</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>10</td>
<td>8</td>
<td>80</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>10</td>
<td>8</td>
<td>80</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>10</td>
<td>8</td>
<td>80</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>10</td>
<td>7</td>
<td>70</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>10</td>
<td>7</td>
<td>70</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>10</td>
<td>4</td>
<td>40</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>10</td>
<td>4</td>
<td>40</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

At the time of reporting the trust was not meeting the target in 10 out of 11 of the mandatory training modules for medical and dental staff at Pilgrim Hospital. Note that due to the small number of medical and dental staff at Pilgrim Hospital the target was not met if just one member of staff had not completed the training.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and health visiting staff in urgent and emergency care is shown below:
Pilgrim Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Support</td>
<td>22</td>
<td>34</td>
<td>65</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>31</td>
<td>34</td>
<td>91</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>22</td>
<td>34</td>
<td>65</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>29</td>
<td>34</td>
<td>85</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>28</td>
<td>34</td>
<td>82</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>20</td>
<td>34</td>
<td>58</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>23</td>
<td>34</td>
<td>68</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>28</td>
<td>34</td>
<td>82</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>26</td>
<td>34</td>
<td>76</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>29</td>
<td>34</td>
<td>85</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>16</td>
<td>34</td>
<td>47</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
<td>TBC</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>14</td>
<td>N/A</td>
<td>N/A</td>
<td>90</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At the time of reporting Pilgrim Hospital met the trust target in one out of the 11 mandatory training modules for qualified nursing and health visiting staff.

(Source: Routine Provider Information Request (RPIR) – Training)

Some medical and qualified nursing staff had completed additional resuscitation training at an advanced level. A breakdown of compliance for advanced resuscitation training is shown below.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of qualified nursing staff</th>
<th>Number of medical staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Life Support</td>
<td>12 (25%)</td>
<td>19</td>
</tr>
<tr>
<td>European Paediatric Advanced Life Support</td>
<td>9 (34%)</td>
<td>19</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>27 (73%)</td>
<td>Not Known</td>
</tr>
<tr>
<td>Paediatric Immediate Life Support</td>
<td>29 (74%)</td>
<td>11</td>
</tr>
</tbody>
</table>

There was a trust wide policy for sepsis management and staff were aware of it. Staff received training on sepsis management; including the use of sepsis screening tools and the use of sepsis care bundles. At the time of reporting 74% of qualified nursing and health visiting staff had completed this training. This was worse than the trust target of 90%.

Safeguarding

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training from April 2017 to October 2017 for medical/dental staff in urgent and emergency care is shown below:
Pilgrim Hospital – medical / dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>10</td>
<td>8</td>
<td>80</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>10</td>
<td>8</td>
<td>80</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>10</td>
<td>7</td>
<td>70</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>10</td>
<td>7</td>
<td>70</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>10</td>
<td>6</td>
<td>60</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for any of the safeguarding training modules for which medical and dental staff were eligible at Pilgrim Hospital. Note that due to the small number of medical and dental staff at Pilgrim Hospital the target was not met if just one member of staff had not completed the training.

A breakdown of compliance for safeguarding training from April 2017 to October 2017 for qualified nursing and health visiting staff in urgent and emergency care is shown below:

Pilgrim Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>33</td>
<td>34</td>
<td>97</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>33</td>
<td>34</td>
<td>97</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>33</td>
<td>34</td>
<td>97</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>33</td>
<td>34</td>
<td>97</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>28</td>
<td>34</td>
<td>82</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met for four out of five safeguarding training modules for which qualified nursing and health visiting staff were eligible at Pilgrim Hospital.

(Source: Routine Provider Information Request (RPIR) Training)

Prevent Duty training was mandatory for staff and included in both children and adults safeguarding training. The aim of Prevent is to give staff an awareness and knowledge of what extremism and radicalisation are and how people may be drawn into terrorism.

Safeguarding children standards produced by the Royal College of Emergency Medicine (RCEM) were met in the emergency department (ED); medical and nursing staff had been trained to an appropriate level and staff told us they had good, 24-hour, access to a senior paediatrician and/or senior consultant within the ED for any child welfare issues.

The executive lead for safeguarding was the director of nursing who was supported by the deputy chief nurse. Policies, procedures, protocols and frameworks relating to safeguarding were in place and readily available to staff. Staff we spoke with had a good understanding of safeguarding and could describe the actions they would take if they suspected a patient required safeguarding.

For the reporting period November 2016 to October 2017 a total of 13 safeguarding alerts had been raised by the ED.

There were processes in place for the identification and management of people at risk of abuse (including domestic violence). However these were not always followed. For example, a ‘SAFER’
tool was to be completed for all children admitted to the emergency department. This tool is based on the SAFER communication tool developed by the Department of Health, to provide a consistent approach to identifying and managing children at risk of abuse. We reviewed 17 sets of paediatric ED records for children admitted between April 2017 and January 2018. Of these, the SAFER tool had not been completed in 10 out of 17 records.

The ED monitored use of the SAFER tool through the trust’s safeguarding audit. For the reporting period July 2017 to December 2017 the SAFER tool was in use and completed appropriately in only four out of 26 patient records.

The ED did not have a Child Protection Information Sharing System (CP-IS) in place. CP-IS allows health and social care staff to share information securely to protect vulnerable children. However, a process was in place to identify vulnerable children through the trust electronic records system.

Systems were in place for recording and reporting suspected female genital mutilation (FGM). Staff received training as part of their children and adults safeguarding training and demonstrated to us a good understanding of FGM and could describe the actions they would take if they suspected FGM had taken place. FGM is defined as the partial or total removal of the female external genitalia for non-medical reasons.

Appropriate arrangements were in place to enable a patient assessed to be at risk of suicide or self-harm to remain safe. Staff used an ‘Emergency Department Adult Mental Health Triage Form’ designed to help staff consider the risk to the patient of self-harm or suicide and referred to the mental health liaison and/or crisis teams where required.

Qualified staff were aware of the Mental Health Act S5(2) doctor’s holding power and S5(4) nurse’s holding power and told us they would seek urgent advice from the mental health liaison services provided by the local NHS mental health trust.

The trust had policies and procedures in place for extra observation or supervision, restraint and, if needed, rapid tranquillisation and these were easily accessible to staff.

**Cleanliness, infection control and hygiene**

The Care Quality Commission (CQC) uses national surveys to find out about the experiences of people who use NHS services. As part of the CQC emergency department survey (October 2017), questionnaires were sent to people who had used emergency department services Between October 2016 and March 2017. Responses were received from 333 patients at this trust. The trust scored ‘about the same’ as other trusts for describing the department as clean.

Standards of cleanliness and hygiene were monitored and maintained through local cleaning and hand hygiene audits, staff training and trust wide infection prevention and control policies and procedures.

For the reporting period February 2017 to January 2018 the emergency department (ED) scored an average 88% compliance in their local cleaning audits. This was worse than the trust target of 95%. The trust target had only been met in one out of the 12 months and actions plans had not been submitted for the remaining 11 months.

Hand hygiene audits were undertaken to measure compliance with the World Health Organisation’s (WHO) ‘5 Moments for Hand Hygiene’. These guidelines are for all staff working in healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. For the reporting period April 2017 to February 2018 the ED scored an average 98% compliance in their hand hygiene audits.

As part of the safety and quality dashboard (SQD) the ED monitored the care received by patients who had a urinary catheter and who had a peripheral cannula. A urinary catheter is a tube inserted into a patient's bladder to allow drainage of urine. A peripheral cannula is a small tube inserted into
a vein to allow the administration of medicines. Both can be associated with increased risk of infections for patients.

A breakdown of compliance for urinary catheter from December 2016 to November 2017 for Pilgrim Hospital is shown below (note that due to the small number of urinary catheters the target was not met if just one catheter did not have all metrics completed):

<table>
<thead>
<tr>
<th>Metric Title</th>
<th>SQD mean score (%)</th>
<th>Lowest score (%)</th>
<th>Highest score (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary catheter record demographics correct</td>
<td>87.5</td>
<td>50</td>
<td>100</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Documented evidence why catheter needed</td>
<td>50</td>
<td>0</td>
<td>100</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Urinary catheter bags secure</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
</tbody>
</table>

A breakdown of compliance for Peripheral cannulas from December 2016 to November 2017 for Pilgrim Hospital is shown below (note data was not submitted for January 2017):

<table>
<thead>
<tr>
<th>Metric Title</th>
<th>SQD mean score (%)</th>
<th>Lowest score (%)</th>
<th>Highest score (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral cannula labelled correctly</td>
<td>34.6</td>
<td>0</td>
<td>80</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>VIP chart demographics correct</td>
<td>50.7</td>
<td>12.5</td>
<td>83.3</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>VIP chart completed</td>
<td>63.8</td>
<td>28.6</td>
<td>100</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

Environment and equipment

The Emergency Department (ED) had one triage room, 10 major cubicles, three minor cubicles, one ‘fit to sit’ room, a see and treat room, a plaster room, a clean procedure room, four resus bays, three rapid assessment and treatment (RAT) cubicles, one waiting room and a quiet relatives room (which was also used as a mental health assessment room). The location of the ED was within a suitable distance of necessary supporting services for example, theatres, computed tomography (CT), and the helipad.

The layout of ED was not suitable for the number of admissions the service received. During our inspection we saw a number of occasions where there was significant overcrowding with patients remaining in the department for over 12 hours. Throughout our inspection we saw patients being cared for on trolleys in the central area as there were no free cubicles to use. This meant patient privacy and dignity was comprised and there was a risk to safety as it would be difficult to evacuate the area in an emergency or to assess and treat a patient who became unwell.

Staff spoke of their concerns regarding the size of the department and gave an example where there had been a delay navigating a resuscitation trolley to a patient’s bedside due to the number of trolleys and beds in the department. We observed patients in the central area receiving clinical treatment without the use of privacy screens and one patient told us they had refused their diuretics (medicines that can cause a patient to pass urine more frequently) because they felt uncomfortable “climbing off a trolley” in the central area. Throughout this inspection the department felt overcrowded and ‘chaotic’ and we observed, on a number of occasions, staff struggling to manoeuvre, beds and equipment due to the number of trolleys and beds within the department.
The ED did not accommodate the needs of children, young people and accompanying families in line with the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (2012). There was no audio and visual separation of the children’s waiting area from the adult section and no dedicated clinical cubicle or trolley space. Whilst one resus bay had been identified for the care of a child or young person we did not see where the décor around this bed space differed from that of an adult resus bay. Murals, mobiles, posters and colourful decoration help allay anxiety and make clinical assessment and treatments much easier for all concerned.

There was not a dedicated room for conducting assessments of adults and children with mental health conditions. Staff used a relative’s room or assessed patients on trollies or in a waiting area. The relative’s room had multiple ligature points and the door did not have a viewing panel. Staff could not exit the room safely and the furniture could be used to barricade the door. The room had two windows which could be opened far enough for a person to wedge themselves against a partitioning wall.

Following our inspection the trust told us, and we saw, there were plans to refurbish the relative’s room in line with Psychiatric Liaison Accreditation Network (PLAN) standards (2017). The trust was waiting final confirmation on funding from their commissioners. In the interim, a risk assessment was in place and staff used an ‘Emergency Department Adult Mental Health Triage Form’ designed to help staff consider the risk to the patient of self-harm or suicide.

Four ligature cutters were available in the ED and were easily accessible to staff. Ligature cutters were stored in the resuscitation area and on the adult resuscitation trolley in the main department.

Appropriate resuscitation equipment for adults and children was available in the resus area. In addition a difficult airway trolley (DAT) was available in resus and a further adult resuscitation trolley was available in the main department.

We saw where resuscitation equipment was safe and ready for use in an emergency. Single-use items were sealed and in date and emergency equipment had been serviced. However, records indicated resuscitation equipment had not always been checked daily or weekly in line with trust policy. For example, we saw where the paediatric resuscitation trolley had not been checked on four occasions in January 2018 and seven occasions (as of 15 February 2018) in February 2018.

As part of the safety and quality dashboard (SQD) the ED monitored monthly if appropriate checks on resuscitation equipment had been fully completed. Data for February 2017 to January 2018 showed appropriate checks had not been completed for seven of the 11 months (data was not collected for December 2017).

There were arrangements in place for safely managing waste and clinical specimens. During this inspection we observed clinical waste to be disposed of appropriately.

Patient equipment was appropriately maintained. All the equipment we looked at across the department was in date for service and all equipment had a visible safety tested sticker demonstrating when the equipment was next due for service.
Assessing and responding to patient risk

Emergency Department Survey 2016

The trust scored “about the same as” other trusts for all of the five Emergency Department (ED) Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>7.2</td>
<td>About the same as other</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.3</td>
<td>About the same as other</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait before</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.3</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel</td>
<td>9.5</td>
<td>About the same as other</td>
</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td>trusts</td>
</tr>
</tbody>
</table>

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

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median over the entire 13 month period from November 2016 to October 2017.

From November 2016 to March 2017 the median time to initial assessment was between 24 and 26 minutes compared to the England average of seven minutes. From April 2017 to October 2017 the trust’s median time to initial assessment fell considerably to nine to ten minutes each month. This was much closer to the England average of seven minutes.

Ambulance – Time to initial assessment from November 2016 and October 2017 at United Lincolnshire Hospitals NHS Trust

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

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

From December 2016 to November 2017 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Pilgrim Hospital. However the percentage of these over 30 minute journeys that lasted over 60 minutes has shown an upward
trend over the time period.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Pilgrim Hospital**

![Bar chart showing the number of journeys with turnaround times over 30 minutes from Dec-16 to Nov-17.](chart)

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Pilgrim Hospital**

![Line chart showing the percentage of journeys with turnaround times over 30 minutes from Dec-16 to Nov-17.](chart)

(Source: National Ambulance Information Group)

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From November 2016 to October 2017 the trust reported 5,909 “black breaches”, with a variable trend over time, which can be seen in the graph below.

![Line chart showing the number of black breaches from Nov-16 to Oct-17.](chart)

The number of “black breaches” reported on a weekly basis ranged from 36 to 239. In the most recent reported month the number of “black breaches” ranged from 79 to 221. The trust noted that work done earlier in the year to open a new Rapid Assessment and Treatment (RAT) area at Lincoln did have a significant effect with reducing delays. However, later in the year, from
October onwards, delays began to increase again. This coincided with increasing demand and a new electronic handover system from East Midlands Ambulance Service (EMAS). It has been reported that the system suffers from faulty terminals and difficulties connecting to 3G - crews report having to go back to base before being able to download handover forms. Work is in progress with EMAS to improve this situation.

(Source: Routine Provider Information Request (RPIR) AC12a – Black Breaches)

The trust had an emergency department risk assessment tool. This was an electronic tool that calculated the risk of the department and rated it as either red, amber or green. Staff inputted data hourly, and the tool calculated the level of risk. This gave an ‘at a glance’ look at the number of patients in ED, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where the risk was. However, we were not assured this tool was updated appropriately. On the last day of our inspection, despite significant pressures within the ED, the tool had not been updated for 12 hours. This meant at that current time there was no ‘at a glance’ oversight of the department.

During our inspection we observed significant handover delays for patients arriving by ambulance. We saw delays of patients waiting over two hours before being clinically assessed by the medical team. During our inspection we found 28 patients who had waited beyond the recommended 15 minutes to be clinically assessed by the trust medical team. Time varied between 20 and 153 minutes. Data provided by the local NHS ambulance trust demonstrated that for the week of this inspection 437 patients attended pilgrim hospital of this 82% of patients waited over 15 minutes to be handed over to the trust. 141 patients were waiting between 30 and 59 minutes, 72 patients between 60 and 120 minutes, 27 patients between two and four hours and two patients waited four or more hours.

We saw there was not an effective system for monitoring patients in the ambulance corridor for any deterioration. A service level agreement was in place with the local NHS ambulance trust whereby ambulance staff had responsibility for patients until handed over to the trust. Where a patient were to deteriorate the patient would be escalated to the nurse in charge. However, our observation of these patients demonstrated ED staff did not have an oversight of the patients presenting condition and/or any deterioration.

We escalated our concerns to the trust’s executive team both during and following our inspection. The trust provided additional information to assure us of actions they were taking to protect patients from avoidable harm. However, we were not assured by the actions the trust had taken. Following our inspection we served an urgent Notice of Decision (NoD) under Section 31 of the Health and Social Care Act 2008. The NoD was served as we found evidence to suggest the quality of health care in relation to handover delays and the monitoring of patients in the ambulance corridor required significant improvement.

The department had three rapid assessment and treatment (RAT) cubicles for the early assessment of ‘majors’ patients arriving by ambulance. However, we saw the RAT process was ineffective at reducing ambulance handover times. Patients were waiting up to two hours before being clinically assessed by the RAT team.

The ED did not have a clear streaming and/or triage process in place for patients arriving at the front door of the department. Patients arriving by the front door were not booked into the department until after the streaming process had taken place. This meant staff had no way of knowing how long the patient had been in the department, nor did it allow the dedicated streaming nurse oversight of the patient’s condition. The inspection team were concerned that patients were
not seen in order of priority and the system did not allow early recognition of those patients who needed to be treated immediately in the majors or resus areas of the department.

We escalated this at the time of our inspection. Senior staff told us the streaming nurse would be placed alongside the receptionist in order to be able to assess the patient immediately upon arrival. When we returned on 17 February 2018, there appeared to be some confusion as to what was expected of staff and the system appeared to be operating as it had at the start of our inspection. We reviewed the ED records for 20 patients (18 adults and two children) admitted via the front door of the department. Twelve records indicated a streaming time the same as or earlier than the arrival/booking in time. We were not assured therefore that the trust had an accurate oversight of performance in this area.

The Royal College of Emergency Medicine (RCEM) ‘Initial assessment of emergency department patients’ suggests a detailed triage assessment should be made within 15 minutes of the patient’s arrival. We reviewed the ED records for 20 patients (18 adults and two children) admitted by the front door of the department. Time from arrival to triage varied between 0 and 190 minutes. Our review of records showed two patients waited 15 minutes or less, four patients waited between 15 and 30 minutes, two patients waited between 30 and 60 minutes and six patients waited 60 minutes or more. Five patient records did not have a triage time recorded.

As part of the safety and quality dashboard (SQD) the ED monitored the percentage number of patient triaged within 15 minutes. Data for February 2017 to January 2018 showed an average 82% of patients were triaged within 15 minutes. However, we were not assured of the accuracy of this figure. On the last day of our inspection we overheard two nurses discussing what time they needed to document as the triage time. The senior of the two nurses advised that the initial assessment time (streaming time) should be recorded.

Staff told us they did not use a nationally recognised tool for triaging patients and we were not assured the streaming process allowed for the early detection of an acutely unwell patient. A national early warning scoring system (NEWS) and paediatric early warning scoring system (PEWS) were not routinely used as part of the streaming process. An early warning score is a guide used by healthcare staff to quickly determine the degree of illness of a patient and prompts support from medical staff and/or senior nursing staff when required. We reviewed ED records for 18 children and found PEWS had not been completed at the initial assessment in 10 records. We were not therefore assured staff were able to recognise the deteriorating physical health of a child.

Once in the main ED nursing staff used NEWS and PEWS to record routine physiological observations such as blood pressure, temperature, respiratory rate and heart rate. Observations were recorded electronically and included a ‘track and trigger’ system whereby scores were displayed electronically within the department. However, there was not a process in place for monitoring the NEWS or PEWS of those patients not yet handed over by ambulance staff nor was there a process in place for displaying NEWS or PEWS for those patients placed in the central area of the department. This meant staff did not have an oversight of all patients in the department.

A paediatric emergency response team (PERT) were available onsite to assist in the care of the deteriorating child. However, on the second day of our inspection, there was only one paediatric registered (RSCN) nurse on-site based on the children’s ward. This meant if PERT support had been required in the ED the RSCN would not have been able to attend. Following our inspection the trust told us an additional trained Paediatric Nurses were available to attend if PERT support had been required and the Paediatric Matron was on site.
There was significant overcrowding in the emergency department. Patients frequently remained in the emergency department at Pilgrim Hospital for over 12 hours. We saw 14 patients had waited on hospital trolleys for between two and 17 hours. Patients were not always placed on beds or pressure relieving mattresses in a timely manner, despite their clinical assessments indicating they were at risk of tissue damage. All 14 patients were classified as 'at risk of tissue damage as a result of pressure'. One patient had documented red areas on admission and was not placed on a pressure relieving mattress despite being in the department for over seven hours.

Trust policy stated that when a patient had been in the department for four or more hours they should have a further pressure area risk assessment commenced; this had not been completed for any of the 14 patients. Staff told us they did not have the appropriate documentation; however we saw sufficient assessment booklets available in the department.

During our inspection we asked the trust for assurance around the actions it would take to address this concern. The trust told us they had created a protocol that was to be posted all over the department and given to each member of staff which described when they should put the patient on a mattress and bed and who to escalate to if they could not find a bed or mattress.

We returned to the department on the following day. We spoke with the nurse in charge and looked in the department for the protocols. We did not see protocols displayed, staff confirmed they had not received this, there had been no communication in the department communication book and the nurse in charge had not been briefed. We discussed with the site duty manager and a short while after we saw protocols had been displayed in the department.

Despite the protocols being displayed we found a further four patients who had not been placed on beds and or pressure relieving mattress and there had not been any action taken in line with the protocol. We escalated these four patients to the nurse in charge. The trust provided additional information to assure us of actions they were taking to protect patients from avoidable harm. However, we were not assured by the actions the trust had taken. Following our inspection we served an urgent Notice of Decision (NoD) under Section 31 of the Health and Social Care Act 2008. The NoD was served as we found evidence to suggest there was no effective system in place to assess and monitor the ongoing care and treatment to patients whilst in the emergency department.

Where appropriate, nursing staff escorted patients when attending and waiting for diagnostics and when transferring to a ward. However, staff told us, and we observed the remaining patients were left without a nurse for long periods of time. When additional staff were allocated to the department to provide cover, they did not always receive an appropriate handover.

There was not a formal process in place for a debrief/ other support after involvement in aggressive or violent incidents.

During our inspection we reviewed 70 sets of adult patient observations and found nursing staff had completed and escalated NEWS appropriately.

Patients with a suspected infection or a NEWS of five or more were to be screened for sepsis, a severe infection which spreads in the bloodstream. Patients being treated for sepsis were to be treated in line with the ‘Sepsis Six Bundle’, key immediate interventions that increase survival from sepsis. There is strong evidence that the prompt delivery of ‘basic’ aspects of care detailed in the Sepsis Six Bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour. Of the 70 sets of adult patient observations we reviewed, 11 patients had triggered a sepsis screen. Of these, nine had been screened appropriately. Of the nine that had been screened five had been treated
appropriately in line with the ‘Sepsis Six Bundle’. Of the two patients not screened neither had ‘red flag (severe) sepsis’.

Staff had access to 24/7 mental health liaison and/or other specialist mental health support if they were concerned about risks associated with a patient’s mental health. Liaison services were available between the hours of 8am and 10pm and crisis team covered from 10pm to 8am. Staff could contact the team(s) directly through a mobile phone number. Staff told us the liaison team typically responded within one hour of referral and the crisis time within four hours of referral.

At the time of our inspection the ED did not have arrangements in place to provide a place of safety. The term ‘place of safety’ is used in the Mental Health Act 1983. Section 136 of the Act gives police officers the power to remove an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a ‘place of safety’ where they may be assessed by a doctor. However, plans submitted by the trust to refurbish the relative’s room were in place and awaiting commissioner approval. In addition, the ED was fully compliant with the pathway requirements for Section 136 as a result of the Policing and Crime Act (2017).

Local Safety Standards for Invasive Procedures using the national Safety Standards for Invasive Procedures were in place and had been assessed against all invasive procedures carried out in the department.

**Nurse staffing**

The trust reported their registered nursing staff numbers, as of October 2017, as shown below. For all sites there were 230.4 WTE planned staff and 230.0 in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td>88.6</td>
<td>73.4</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing)*

**Vacancy rates**

From November 2017 to October 2017 the trust reported a vacancy rate of 19.8% for nursing and midwifery staff in urgent and emergency. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td>11.5</td>
<td>23.8</td>
</tr>
</tbody>
</table>

Vacancy rates at Pilgrim Hospital were much higher than the trust target of 11.5%.

*(Source: Routine Provider Information Request (RPIR) Vacancy)*

**Turnover rates**

From 30 November 2016 to 31 October 2017 United Lincolnshire Hospital reported an annual turnover rate of 5.2% for nursing and midwifery staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td>3.0</td>
<td>4.5</td>
</tr>
</tbody>
</table>
The turnover rate for nursing staff at Pilgrim Hospital was below the trust voluntary target of 7%.

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

Sickness rates

From October 2016 to September 2017 United Lincolnshire Hospital reported a sickness rate of 5.5% for nursing staff in urgent and emergency care. The trust’s target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Sickness rates for qualified nursing and health visiting staff from October 2016 to September 2017 was similar to the trust’s target at Pilgrim Hospital.

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

Bank and agency staff usage

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 17.7% with a further 4.6% of shift remaining unfilled. A breakdown by staff type is shown below:

**Pilgrim Hospital Boston**

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>1,987 (16.6%)</td>
<td>725 (6.1%)</td>
<td>826 (6.9%)</td>
<td>11,960</td>
</tr>
<tr>
<td>Unregistered</td>
<td>1 (0.0%)</td>
<td>1,608 (36.0%)</td>
<td>712 (15.9%)</td>
<td>4,468</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Nursing bank agency)

The nurse staffing levels and skill mix were not sufficient to meet the needs of patients. There was no allocated nurse for those patients being treated in the middle area of the department or on corridors and we noted that one nurse was caring for up to 21 patients at any one time. Nurses were escorting patients to wards and CT scan which left the remaining patients without a nurse for long periods of time. During our inspection we found 14 patients who had not had their care and treatment carried out in a timely manner. For example, one patient with a diagnosed acute kidney injury (AKI) was waiting over six hours for intravenous fluids to be administered. The inspection team escalated the care of this patient to the nurse in charge. A further patient was overdue time critical medicines by four hours. The inspection team had to alert nursing staff to this. Where additional staff were allocated to the department, we saw they did not receive an appropriate induction to the department or an appropriate patient handover.

During our inspection we asked the trust, for assurance around the actions they would take to address our concerns over the coming weekend. We were told a ‘mini induction’ would take place for any additional nurses working in the department including bank and agency nurses and that additional nurses would be allocated to work with a substantive nurse. Additional agency nurse support had also been secured for the weekend and the following six weeks.
We returned to the department the following day and spoke with an agency nurse, who told us they had not been “formally” inducted to the department; they had been shown round the department only. This did not include orientation to emergency equipment or fire safety equipment or procedures. The induction had not been documented. We were therefore not assured that staff had been safely and effectively inducted into the work environment, which could place patients at risk of avoidable harm.

The trust provided further additional information to assure us of actions they were taking to protect patients from avoidable harm. However, we were not assured by the actions the trust had taken. Following our inspection we served an urgent Notice of Decision (NoD) under Section 31 of the Health and Social Care Act 2008. The NoD was served as we found evidence to suggest the trust was failing to ensure that there was a sufficient number of suitably qualified and competent nursing and support staff available to work in the department. Patients with deteriorating clinical conditions were at risk of harm as the trust was not ensuring that the staff on shift were managed or deployed in a way that addressed their needs.

The emergency department (ED) at Pilgrim Hospital did not have a minimum of one children’s nurse present on each shift in line with the ‘Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings’ document titled, “Standards for Children and Young People in Emergency Care Settings” (2012) which recommends that ‘all clinical staff should have minimum competencies including recognition of the sick or injured child, basic life support skills, the ability to initiate appropriate treatment in accordance with locally agreed protocols’. Registered nurses (adult) had not received additional competencies above and beyond paediatric resuscitation training, to provide them with the skills required to recognise a child whose condition may be deteriorating.

During our inspection we asked the trust for assurance around the number of staff who were competent to care for children. Information received from the trust stated “All band 6 and 7 nurses in the department have Emergency Paediatric Advanced life support and there is at least one of these on every shift, we are assured that this training is sufficient for department needs”. (‘The course is intended to provide training for multi-disciplinary healthcare professionals in the early recognition of the child in respiratory or circulatory failure and the development of the knowledge and core skills required to prevent further deterioration towards respiratory or cardiorespiratory arrest’).

There was a protocol in place for the paediatric ward staff to support the emergency department staff in the event of sudden deterioration of a child; however the primary responsibility of staff on the paediatric ward was for the paediatric ward. We were not assured that this protocol would be enacted appropriately as staff in the emergency department did not have the additional competencies to recognise the deteriorating child and therefore would not recognise when they needed to summon help to the department. Furthermore, we found, on one particular day of our inspection, there was only one registered children’s nurse on the paediatric ward, who confirmed they would not be able to support the staff in the emergency department if required as they needed to remain on the ward.

We returned to the ED the following day at 11:00, the nurse in charge told us that they were EPLS trained. A further nurse was present on shift from 12pm who also possessed this qualification. Both nurses told us they had no additional competencies to care for children, which is not sufficient to demonstrate that staff were competent to care for sick or deteriorating children. Therefore children in the department were placed at risk of harm due to staff not having
competencies to provide safe and effective care. In addition, we spoke with two nurses working in the resuscitation area of the department. One band five nurse, who had worked in the department for three months, confirmed they had basic life support training, but had no additional competencies to care for children. The second nurse in the resuscitation area was from the intensive care unit, they confirmed they had adult advanced life support training but no paediatric resuscitation training or additional competencies to care for children.

The trust provided further additional information to assure us of actions they were taking to protect children from avoidable harm. However, we were not assured by the actions the trust had taken. Following our inspection we served an urgent Notice of Decision (NoD) under Section 31 of the Health and Social Care Act 2008. The NoD was served as we found evidence to suggest children within the emergency department were at risk of harm because registered nurses (adult) had not received additional competencies above and beyond paediatric resuscitation training, to provide them with the skills required to recognise a child whose condition may be deteriorating.

A combined medical and nursing handover took place in the ED twice daily. We observed one handover and saw detailed discussions take place regarding patients in the department. However, whilst numbers of patients awaiting handover were discussed we did not see where patient’s presenting conditions were discussed in any great detail.

A team of 10 advanced care practitioners (ACPs) worked in the department to support nursing and medical staff. ACPs are clinical professionals who have developed their skills and theoretical knowledge to a very high standard and are able to carry out tasks similar to that of a junior doctor.

**Medical staffing**

The trust reported their medical & dental staff numbers as below as of October 2017. For all sites there were 85.2 WTE planned staff and 53.8 in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td>33</td>
<td>18</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

**Vacancy rates**

As of October 2017 the trust reported a vacancy rate of 32.2% for medical and dental staff in urgent and emergency. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td>12.0</td>
<td>35.1</td>
</tr>
</tbody>
</table>

Pilgrim Hospital had a much higher vacancy rate than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) Vacancy)

**Turnover rates**

From 30 November 2016 to 31 October 2017 United Lincolnshire Hospital reported an annual turnover rate of 8.8% for medical and dental staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate by site is shown below:
The turnover rate for medical and dental staff at Pilgrim Hospital was above the trust target, however this only related to one whole time equivalent (WTE) staff.

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

Sickness rates

From October 2016 to September 2017 United Lincolnshire Hospital reported a sickness rate of 6.6% for medical and dental staff in urgent and emergency care. The trust’s target rate for sickness is 4.5%.

Sickness rates by site can be seen below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>9.5</td>
</tr>
</tbody>
</table>

The sickness rate for medical and dental staff from October 2016 to September 2017 was above the trust’s target at both sites.

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

Bank and locum staff usage

The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) Medical agency locum)

Staffing skill mix

For August 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 48 whole time equivalent staff working in Urgent and Emergency Care at United Lincolnshire Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>33%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>10%</td>
<td>35%</td>
</tr>
<tr>
<td>Junior*</td>
<td>32%</td>
<td>23%</td>
</tr>
</tbody>
</table>
**Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty**
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Consultant presence in the emergency department (ED) was 9am to 9pm Monday to Friday and 9am to 4pm at weekends. This was less than the Royal College of Emergency Medicine (RCEM) recommendation of 16 hours per day. Outside of these hours there was a consultant on call.

Middle grade and junior doctors were present 24 hours every day.

At the time of our inspection there was one substantive consultant in ED who was also the head of service for the department. A further five locum consultants supported the ED team. Staff told us this was “manageable” but did mean the RCEM 16 hour standard was not met.

The trust human resources department was responsible for undertaking the appropriate checks for all NHS locum staff. Within the ED, locum doctors received an induction to the department. However, this was informal and not documented.

A combined medical and nursing handover took place in the ED twice daily. We observed one handover and saw detailed discussions take place regarding patients in the department. However, whilst numbers of patients awaiting handover were discussed we did not see where patient’s presenting conditions were discussed in any great detail.

Pilgrim ED did not have a consultant with sub-specialist training in paediatric emergency medicine. In the case of a medical emergency staff had access to appropriate medical paediatric support. There was a consultant paediatrician and a middle grade on call and available 24/7.

Medical staff looking after children were not appropriately trained in paediatric immediate life support (PILS) and advanced paediatric life support (APLS). As of February 2018 one doctor was PILS trained and five doctors were APLS trained.

**Records**

Records of patient’s care and treatment were in paper format and included an ‘accident and emergency record’, an ‘adult inpatient risk assessment booklet’ and an emergency department (ED) safety checklist’. We saw records were available for each patient who had been booked into the department.

In the ED, records were stored in racks outside the patient cubicles, so were easily accessible for staff. Staff never left this area unattended, so records remained secure.

Records were not always up to date. For example, we reviewed the ED records for 20 patients (18 adults and two children) admitted through the front door of the department. Of these, five patient records did not have a triage time recorded.

Risk assessments for pressure areas were not always undertaken and/or acted on appropriately in line with trust policy. Trust policy stated an initial assessment was to be completed on admission followed by a further, more detailed assessment when a patient had been in the department for four or more hours. Both were to be completed using nationally recognised assessment tools.

We reviewed the ED records for 24 patients, specifically looking at nursing care interventions. Of these, six had not had a pressure area risk assessment on admission and 14 patients, who had
been in the department four or more hours, had not had a further pressure area risk assessment completed.

As part of the safety and quality dashboard (SQD) the ED monitored pressure area care risk assessments completed within 24 hours. Data for February 2017 to January 2018 showed an average completion rate of 70% across 11 months (data for December 2016 was not collected). This was worse than the trust target of 90%.

Emergency department safety checklist’s were not always in place or fully completed. Of the 24 records reviewed (as above), six records did not contain a checklist. Where a checklist was in place seven had not been completed appropriately.

Patient records did not prompt staff to record patient’s mental health needs. This meant staff were not confident patient records would tell them if a patient had an underlying mental health diagnosis. For those patients with pre-existing mental health conditions staff were able to contact the specialist mental health trust if required.

The mental health liaison team documented their review of a patient in the ED patient record. This meant the patient’s mental health assessment, care plan and risk assessment were accessible to staff in the ED.

Staff told us they had a very good working relationship with the mental health liaison team and could approach them at any time for advice if for example; a patient attempted to discharge themselves or refused treatment.

Staff had access to patient-specific information, such as care programme approach (CPA) care plans, positive behaviour support plans, health passports and communication aids through the mental health liaison team.

**Medicines**

Medicines and medicines related stationery were managed appropriately. The ordering, storage and administration of controlled drugs (CDs) were in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Records indicated where CDs had been checked daily in line with trust policy.

Medicines requiring refrigerated storage were stored appropriately and within recommended temperature ranges. Records indicated where fridge temperature checks had been completed daily by staff and that staff knew the process to follow should the temperature not be within the required range.

Emergency medicines were stored on resuscitation trolleys, trolleys were secure, sealed with tamper evident fastenings and checked daily.

We reviewed nine medicine administration records. Our review showed patients were not always getting their medicines in a timely manner and when they needed them. For example, we found one patient with a diagnosed acute kidney injury (AKI) who had been waiting over six hours for intravenous fluids to be administered and a further patient was overdue time critical medicines by four hours. Both incidents were escalated to the nurse in charge at the time of inspection.

Medicines were monitored as part of the emergency department (ED) safety and quality dashboard (SQD). Data for the reporting period February 2017 to January 2018 showed 100% of patients had allergies clearly documented in the prescribing document used and 100% of patients had been given all medicines as prescribed.

The Care Quality Commission (CQC) emergency department survey (2016) asked patients if the purpose of new medication was explained to them in a way they could understand and if they were
told about possible side effects of new medication. Results showed the trust scored ‘about the same’ as other trusts for both questions.

Patients were prescribed antibiotics in accordance with local antibiotic formularies. Local microbiology protocols for the administration of antibiotics were available in the ED and we saw prescribers were using them appropriately. This included a review of treatment following a microbiological sample result becoming available.

Where patients were prescribed an antimicrobial, we saw the clinical indication, dose and duration of treatment had been documented in their ED record appropriately and in line with National Institute for Health and Care Excellence (NICE) guidance.

Where a patient dependent on alcohol or illegal drugs was admitted, they were offered medicines to assist their withdrawal and associated side-effects in addition to a referral to an alcohol clinical nurse specialist if required.

**Incidents**

**Never Events**

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

From January 2017 to December 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 32 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 16 (50% of total incidents)
- Treatment delay meeting SI criteria with eight (25% of total incidents)
- Slips/trips/falls meeting SI criteria with four (12.5% of total incidents)
Information split by site can be found below:

**Pilgrim Hospital**

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Total incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>6</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

*(Source: NHS Improvement - STEIS (01/12/2016 - 30/12/2017)*

Information from our internal computerised database showed between 26 September 2017 and 26 February 2018 there were a total of 512 incidents reported for the Emergency Department (trust wide). The majority of these were graded as no harm (393 incidents). Of the remaining 119 incidents, 77 were graded low harm, 30 were moderate harm, two were graded as abuse and 10 deaths were recorded.

For the reporting period 26 September 2017 to 26 February 2018, 207 patient incidents were recorded for the Emergency Department (ED) at Pilgrim Hospital. The majority of these were graded as no harm (145 incidents). Of the remaining 62 incidents, 43 were graded low harm, 13 were moderate harm, four were graded as severe harm and two deaths were recorded. The top five most frequently reported incidents were, implementation & ongoing monitoring/review – other (20), diagnostic images / specimens - mislabelled / unlabelled (18), delay or failure to monitor (16), pressure ulcer (hospital acquired) (14) and lack of clinical or risk assessment (9).

An incident reporting policy which included the incident grading system and external and internal reporting requirements was available to staff. Incidents, accidents and near misses were reported through the trust’s electronic reporting system.

We spoke with 10 nursing staff and two medical staff specifically about incident reporting. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near
misses, and to report them internally and externally, where appropriate. Staff we spoke with could give us examples of recent incidents they had reported.

Senior staff told us incidents and shared learning from incidents was discussed at handover, safety briefings, newsletters, emails and through a communication book within the department. However, eight out of 10 staff we spoke with said they had not received feedback from incidents they had raised. Staff could not give us examples and neither did we see where changes had been made as a result of an incident.

We were not assured all incidents were raised appropriately. Staff told us, due to receiving little or no feedback; they did not always raise incidents when they occurred.

The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were familiar with the duty of candour and the concepts of openness and transparency. Senior staff were able to give examples of how they had applied the duty of candour when an incident required it.

Mortality and morbidity reviews were held monthly. Mortality and morbidity meetings give health professionals the opportunity to review and discuss individual cases to determine if there could be any shared learning. Medical staff told us all Emergency Department (ED) deaths for the previous month would be discussed as well as, any Coroner reports. We reviewed the minutes of three mortality and morbidity meetings held between October 2017 and December 2017. Meetings were well attended with representation from across the multidisciplinary team and we saw processes were in place to review and discuss individual cases and identify any learning from these.

Safety thermometer

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

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.
Data from the Patient Safety Thermometer showed that the trust reported 0 new pressure ulcers, four falls with harm and 0 new catheter urinary tract infections from December 2016 to December 2017 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Total falls (4)</th>
<th>7.0</th>
<th>5.6</th>
<th>4.2</th>
<th>2.8</th>
<th>1.4</th>
<th>0.0</th>
</tr>
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<tbody>
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</table>

Evidence appendix United Lincolnshire Hospitals NHS Trust
Is the service effective?

Evidence-based care and treatment

The Emergency Department (ED) mostly provided care and treatment based on national guidance including National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) standards. Departmental compliance in for example, sepsis, asthma and consultant sign-off was measured through local and national audits and monitored through quality governance meetings and the patient safety committee.

Local audits included participation in for example, Trauma Audit Research Network (TARN). However, audit participation in other areas was low. For example, the ED had not participated in a number of RCEM audits including for example; ‘Vital signs in children’ and ‘Procedural sedation in adults’, nor did we see evidence of any prescribing audits within the department. Senior leaders told us this was because of the low numbers of substantively employed medical staff within the ED. We were not assured therefore; practice was always in line with national recommendations and quality statements.

Care pathways were available for staff to use. These provided details of the care that was required in line with recognised guidance and provided a proforma to document the care staff had given. Examples of care bundles included; fractured neck of femur, sepsis and venous thromboembolism (VTE). During our inspection we saw good examples where the fractured neck of femur and sepsis pathways had been used appropriately.

We observed one team handover during our inspection. The handover did not refer to the psychological and emotional needs of patients, as well as their relatives / carers.

Patients physical health needs were assessed on admission to the ED. However, records did not prompt staff to record a patient’s mental health needs unless a patient was displaying symptoms of, or had been admitted with, a known mental illness. Staff told us they would seek advice through the liaison team to ensure they were following best practice for assessing and monitoring the physical health of people with severe mental illness.

Patients who were suspected to be experiencing depression were assessed using an ‘Emergency Department Adult Mental Health Triage Form’. This assessment prompted staff to consider a referral to mental health services depending on the level of patient risk.

Staff told us they were able to deal with any violence and aggression in an appropriate way and gave us examples of actions they would take including where they would go for additional support.

Procedures, policies and clinical guidelines were easily accessible to staff through the trust’s intranet.

Older people who were frail or vulnerable received (or got referred for) a comprehensive assessment of their physical, mental and social needs through the hospital frailty service.

Nutrition and hydration

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.
Arrangements were in place in terms of food and drink for patients (and accompanying friends and family) who were in the department for any length of time. The Emergency Department (ED) had a small kitchen area where staff could make refreshments for patients (and accompanying friends and family) and where able, patients were encouraged to help themselves.

The emergency department safety checklist prompted staff at regular intervals to offer patients refreshments. However, checklists were not always in place or fully completed. Of the 24 records we reviewed, six records did not contain a checklist. Where a checklist was in place seven had not been completed appropriately. During our inspection we found a number of patients who had not been offered food and drink for significant amounts of time. We had to escalate this to senior managers on a number of occasions.

During our inspection we found three patients where it had been requested by the medical team that the patient’s fluid input and output was to be monitored through a fluid balance chart. We found fluid balance charts were incomplete or not in place at all. For example, a patient with a diagnosed acute kidney injury (AKI) should have had a fluid balance chart commenced at 1.22am. At 10.50am there was no chart in place. A second patient had a fluid balance chart in place however there was nothing recorded on the chart between 4am and 11.45am despite the patient having had intravenous fluid therapy.

Patient’s nutrition and hydration needs (including those related to culture and religion) were not routinely assessed in the ED. Patient records did not prompt staff to record nutrition and hydration needs.

**Pain relief**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.7 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts. However, it is noted that although there were 333 survey respondents at this trust only 49 participants responded to this specific question.

The trust scored 8.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Patients in the Emergency Department (ED) did not have their pain assessed and managed in line with the Core Standards for Pain Management Services in the UK (2015). Where patients had acute pain, we did not see an individualised analgesic plan appropriate to their clinical condition.

Pain scores were to be assessed hourly and documented on the emergency department safety checklist. However, checklists were not always in place or fully completed. Of the 24 records we
reviewed, six records did not contain a checklist. Where a checklist was in place seven had not been completed appropriately. Despite this we did not see, during our inspection, where patients were in pain.

We reviewed ED records for 18 children, admitted to the department between July 2017 and January 2018, and found 17 out of 18 children had not had a pain score documented.

Pain management was monitored as part of the emergency department (ED) safety and quality dashboard (SQD). Data for the reporting period February 2017 to January 2018 showed an average score of 57% for ‘patient pain score completed’ and an average score of 79% for ‘Patient offered/administered analgesia within 15 minutes’.

We spoke with 15 patients (14 adults and one child) and asked them if they had needed pain killers whilst in the ED and if so, how long they had to wait for them. Where applicable, all of the patients told us they got pain killers almost immediately after they had asked for them.

Registered nurses (RNs) were able to administer simple pain relief using patient group direction (PGDs). Patient group directions provide a legal framework to allow registered health professionals to supply and/or administer specified medicines, to a predefined group of patients without them having to see a doctor. This meant that patient would receive their medication quicker.

Nursing staff had easy and timely access to a senior doctor for prescribing analgesia for severe pain.

**Patient outcomes**

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

Comparing Pilgrim Hospital to other hospitals on the 2016/17 Moderate and Acute Severe Asthma Audit (Adult and Paediatrics), performance was better in two metrics. These were:

- Standard 2a: Vital signs should be measured and recorded on arrival at the ED. Hospital: 44.0%; UK: 26%
- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 64.0%; UK: 25%

The hospital’s performance was worse in two metrics. These were:

- 5a: Within one hour of arrival (acute severe). Hospital: 0.0%; UK: 19%
- 5b: Within four hours (moderate). Hospital: 0.0%; UK: 28%

Note: Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
- Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
- Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
- Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

The hospital’s performance was similar in three metrics (in this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results). These were:

- Standard 1a: O2 should be given on arrival to maintain sats 94-98%. Hospital: 12.0%; UK: 19%
- Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy.
Hospital: 72.2%; UK: 77%

- Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines. Hospital: 45.8%; UK: 52%

The RCEM standard was met in none of the seven standards.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Comparing Pilgrim Hospital to other hospitals on the 2016/17 Consultant Sign-off Audit, performance was better in two metrics. These were:

- Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 29.3%; UK: 9.7%.

The hospital’s performance was similar in two metrics (in this context, ‘similar’ means that the hospital’s performance fell within the middle 50% of results). This was:

- Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Trust: 9.5%; UK: 10.6%.
- Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Hospital: 19.2%; UK: 12.2%.

The national standard was met in none of the relevant metrics.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Comparing Pilgrim Hospital to other trusts on the 2016/17 Severe Sepsis and Septic Shock Audit, performance was better in 0 metrics and worse in five metrics. These were:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. Hospital: 30.4%; UK: 69.1%.
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 1.4%%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. Hospital: 29.4%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 2.2%; UK: 44.9%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 2.2%; UK: 18.4%.

The hospital’s performance was similar in 4 metric(s). In this context, 'similar' means that the trust’s performance fell within the middle 50% of results. These were:

- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 58.7%; UK: 64.6%.
• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 34.8%; UK: 43.2%.

• Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 31.5%; UK: 44.4%.

The national standard was met in 0 of eight of the relevant metrics.  
(Source: Royal College of Emergency Medicine)

RECEM Audit: Vital signs in children 2015/16
The trust did not participate in the RCEM vital signs in children 2015/16 audit.  
(Source: Royal College of Emergency Medicine)

RECEM Audit: Procedural sedation in adults 2015/16
The trust did not participate in the RCEM procedural sedation in adults 2015/16 audit.  
(Source: Royal College of Emergency Medicine)

RECEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16
The trust did not participate in the Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16.  
(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From November 2016 and October 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average. The trust’s performance remained similar across the time period ranging from 6.2% in November 2016 to 7.0% in August 2017.

Unplanned re-attendance rate within 7 days - United Lincolnshire Hospitals NHS Trust

(Source: NHS Digital - A&E quality)
Whilst information about the outcomes of patient’s care and treatment was routinely collected and monitored, we were not assured all relevant staff were using the information collected and/or results to improve patient outcomes. Some senior staff within the Emergency Department (ED) demonstrated little or no knowledge of RCEM audits and as such were unable to tell us where improvements had been made. In addition, we were told the audit lead, responsible for RCEM audits, was not available during our inspection and that they (a senior lead) did not feel confident discussing patient outcomes with the inspection team. None of the senior team were able to show us any actions plans that had been developed as a result of audit outcomes.

**Competent staff**

**Appraisal rates**

The trust provided appraisal rates for staff who required an appraisal from April 2017 to October 2017. As most appraisals are carried out at the end of the financial year figures do not include all staff members. From April 2017 to October 263 urgent and emergency care staff were required to complete an appraisal with 79.1% of these having received an appraisal. This was lower than the trust target of 85%.

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

![Appraisal rates graph](image)

At Pilgrim Hospital 102 urgent and emergency care staff were required to complete an appraisal with 83.3% of these having received an appraisal. This did not meet the trust target of 85%. 79.6% of qualified nursing and health visiting staff had completed an appraisal and 92.3% of medical and dental staff had received an appraisal.
A split by staff group can be seen in the graph below:

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

Staff we spoke with told us there were training opportunities available but it was difficult to attend due to staffing levels. Some staff told us they felt the skills they had developed either in this role or from previous employment was undervalued by senior managers within the department.

Medical staff told us they had good access to teaching within the department. However, locum staff told us they were not allowed to attend ‘junior’ or ‘middle grade’ teaching sessions and did not therefore feel they always had access to clinical guidelines necessary to inform their practice. For example, one locum doctor was unaware there was a fractured neck of femur pathway available in the department.

We were not assured there was an individual and/or team within the Emergency Department (ED) responsible for antimicrobial stewardship. We did not see where data was monitored and feedback provided on prescribing practice at prescriber and/or team level. This did not meet National Institute for Health and Care Excellence (NICE) guidance.

Senior managers told us, a training deficit had been identified for clinical staff leading to patient safety issues regarding blood monitoring, fit testing of respiratory protective equipment face pieces, electronic blood tracking systems, basic life support and mentorship. We saw an action plan in place to ensure all frontline clinical staff were trained in these key skills. However, we were not told when training would be completed.

During our inspection we observed good nursing interventions and staff demonstrated to us they had the skills, knowledge and experience to identify and manage issues arising from patients’ living with for example, mental health conditions, a learning disability, autism and dementia.

The specialist mental health liaison team were participating in an accreditation scheme and had the necessary skills, knowledge and experience to work with patients with learning disabilities, autism or a dementia diagnosis.
Staff demonstrated they had the skills to sensitively manage any difficult behaviour that patients might display.

Poor or variable staff performance was identified and managed appropriately. We saw actions in place to support staff to improve and/or undertake an alternative role within the department. For example, plans were in place to train staff, who had six months or more ED experience, in triage.

**Multidisciplinary working**

We received mixed feedback regarding working relationships amongst the multidisciplinary team. Some staff told us they felt there was no consistency in working practices. For example, practices would change on a daily basis depending on who was leading the team that day. None of the staff we spoke with were able to give us examples of where they felt this had negatively impacted on patient care.

Nursing, medical and day to day leadership of the department was ineffective. The department was chaotic and there was a lack of oversight of patient care. There were insufficient actions to address overcrowding, increased waits and high acuity in the department. At times of high stress it was clear to see how the behaviour of leaders in the department changed, which had a negative impact on the multidisciplinary team.

Arrangements were in place for the care of patients requiring other services within the hospital or healthcare services external to the trust for example, psychiatric liaison services. However, arrangements were not always robust. Medical staff told us of the challenges they faced when referring patients to individual specialties, with patients often waiting a significant length of time to be seen. We were told this was not audited, we were not therefore assured the trust had sufficient oversight of how significant this concern was or, how much of an impact this had on flow through the department.

One middle-grade doctor gave an example where a paediatric registrar had refused to come to the Emergency Department (ED) to review a child because they were too busy and we saw where the children’s ward within the hospital did not always have sufficient children’s trained nurses to allow a nurse to attend ED if requested.

A frailty service was in place for the assessment and treatment of patients who were frail. However, this was only available ‘in-hours’ Monday to Friday, staffed by one individual and there was no dedicated ward available for the patient to be admitted to.

Specialist nurses were available to support and review patients. For example, cardiac assessment nurses (CAT) and alcohol liaison.

When patients were discharged, reception staff generated letters from the department’s electronic system; these were printed off and posted to the patient’s GP.

**Seven-day services**

The Emergency Department (ED) provided a service 24 hours a day, 365 days a year. The Ambulatory Emergency Care Unit (AEC) was open Monday to Friday, 8:30am to 10:30pm.

Patients had timely access to diagnostics such as X-rays and computerised tomography (CT) scans and support services such as pathology and theatres were available 24 hours a day. Diagnostic facilities such as X-ray and ultrasound were available within the ED.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance for Gastrointestinal Haemorrhage: Time to Get Control (2015) states there must be a gastrointestinal bleeding (GI) rota to provide treatment anytime of the day or night, either on-site or as part of an
agreement within a network of providers. During a previous inspection in October 2016 we found, there was no on call GI bleed rota at Pilgrim hospital. At this inspection we found, a full and effective GI bleed rota had been in place since February 2017.

**Health promotion**

National priorities to improve the population’s health were supported through the admission process in the Emergency Department (ED). For example, smoking cessation, obesity, drug and alcohol dependency, dementia and cancer. Questions within the ED documentation prompted staff to explore the patient's current lifestyle.

Patients who might need extra support were identified through the admission process and medical review. This included, patients in the last 12 months of their lives and patients at risk of developing a long-term condition.

Health and condition specific advice was provided through leaflets on the trust’s website. However, we did not see leaflets within the department.

Specialist nurses were available in the hospital and attended the ED following a patient referral. Specialist nurses encouraged patients with monitoring their health, including health assessments and checks, where appropriate and necessary.

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

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

The trust reported that from April 2017 to October 2017 Mental Capacity Act (MCA) level 2 training had been completed by 80.4% of staff within urgent and emergency care. This was lower than the trust target of 90%.

Completion of MCA level 2 training split by staff group is shown below:

**Pilgrim Hospital**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Mental Capacity Act (MCA) level 2 training completed, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified ambulance service staff</td>
<td>100.0</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>94.4</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>65.7</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>50.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>82.5</strong></td>
</tr>
</tbody>
</table>

At Pilgrim Hospital the trust target for MCA level 2 training was met by qualified ambulance service staff (94.4%) and qualified nursing & health visiting staff (94.4%). Medical and dental staff had particularly low training rates.

Deprivation of Liberty training information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

*(Source: Trust Provider Information Request Training)*
At the time of our inspection there were no patients detained under the Mental Health Act. However, staff demonstrated to us an awareness of the additional steps to consider if the patient did not consent to treatment. Staff told us they would get advice on this, if required, from the mental health liaison team.

Staff demonstrated understanding of the issues around consent, and without exception, we saw staff obtaining consent prior to all interventions.

We spoke with 15 patients (14 adults and one child). Without exception, we were told staff asked for consent before any intervention.

Medical staff referred to Fraser guidelines when seeking consent from a child or young person. Fraser guidelines are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

ED staff followed advice contained within Royal College of Emergency Medicine (RCEM): ‘The Mental Capacity Act in Emergency Medicine Practice’. Medical and nursing staff understood the Mental Capacity Act (MCA) and were trained to assess a patient’s capacity.

There had been no Deprivation of Liberty Safeguard applications made by the Emergency Department (ED) during the year preceding our inspection. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

### Is the service caring?

**Compassionate care**

**Friends and Family test performance**

The trust’s A&E Friends and Family Test performance (% recommended) was generally worse than the England average from November 2016 to October 2017. The graph is below:

![A&E Friends and Family Test Performance - United Lincolnshire Hospitals NHS Trust](image)

The trust’s performance ranged from 79.8% in July 2017 to 86.9% in September 2017. This compares to the England range of 86.0% and 88.0%.

The percentage of patients who recommended Pilgrim Hospital was between 75.8% and 83.5%. Results had not changed since our last inspection in October 2016 and the recommended rate had deteriorated over the time period. The response rate for this hospital was between 16.1%
and 18.8% each month. The graph below shows the FFT results for Pilgrim Hospital:

(Source: NHS England Friends and Family Test)

We spoke with 15 patients (14 adults and one child) and six relatives during our inspection of the Emergency Department (ED). Feedback was mostly positive, describing staff as kind, caring and compassionate and without exception staff were reported to be introducing themselves when first meeting patients or relatives. However, most patients and relatives commented on the poor environment, how busy the staff were and how long they had to wait for treatment.

We observed, whilst clearly busy, most staff demonstrating a caring and compassionate attitude towards patients. The team were united by having the drive to deliver the best care they could. However, there were not enough nursing staff in the department to ensure patient needs were met appropriately and in a timely way, on one occasion during our inspection a nurse was caring for 21 patients. We found that staff shortages within the department negatively impacted on the care patients were receiving. We observed patients upset and agitated, patients who had not been offered food and/or drink for a significant amount of time and patients not always receiving their care and treatment in a timely manner.

Leadership in the department did not always ensure patients were treated with kindness, dignity, respect and compassion, at times of high stress it was clear to see how the behaviour of leaders in the department changed, which had a negative impact on the way patients were treated. On one occasion we observed a senior nurse displaying a negative and confrontational attitude towards a paramedic who had just brought in a patient who clearly required immediate resuscitation. These behaviours were displayed in full view of the patient, their relative and the department. In addition, where we (the inspection team), raised concerns regarding patients who had not been placed on beds or pressure relieving mattresses appropriately, we were not assured our concerns were given sufficient priority. For example, on the last day of our inspection where we found an additional four patients who had been on trolleys for a significant period of time, when raising our concerns we were given reasons why this was the case not, actions to rectify the situation.

As a result of poor staffing levels and ineffective leadership, the inspection team considered care in the department to meet the threshold of a safeguarding concern. Safeguarding is a term used to denote measures to protect the health, well-being and human rights of individuals, which allow people, especially children, young people and vulnerable adults, to live free from abuse, harm and neglect. We asked staff if they had raised concerns about the level of care in the ED. Staff told us,
and we saw, where some concerns and actions had been raised as an incident however, due to a lack of feedback or action staff told us they would not always raise their concerns as an incident. We asked the trust to raise the concerns we identified as safeguarding alerts with the local authority.

As part of the safety and quality dashboard (SQD) staff monitored patient dignity monthly. Results for the reporting period February 2017 to January 2018 are shown below (data was not collected for December 2017):

<table>
<thead>
<tr>
<th>Metric Title</th>
<th>SQD mean score (%)</th>
<th>Lowest score (%)</th>
<th>Highest score (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call bell within reach</td>
<td>92.8</td>
<td>75</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient modesty maintained</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Curtains meet &amp; do not enter signs attached</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient reports good communication from staff</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Staff introduce with 'hello my name is…?'</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>90</td>
<td>Yes</td>
</tr>
</tbody>
</table>

During this inspection, we found significant overcrowding in the ED with patients remaining in the department for over 12 hours. This meant patients privacy and dignity needs were not always respected. We saw a number of patients being treated in the middle area of the department or on corridors, these patients did not have access to a patient call bell and as such, would not have been able to easily call a nurse for assistance.

We observed and were told of a number of examples where patient’s privacy and dignity needs had not been met appropriately. One patient, who had not had a drink for several hours, told us they had refused a drink because they did not want to have to climb off a trolley in the central area of the department to go to the toilet. We observed another patient refuse their medicines because the medicines would increase their need to go to the toilet.

**Emotional support**

The environment in the department was not suitable for the care of children and did not meet the standards set by the Royal College of Emergency Medicine (RCEM). There was no audio and visual separation of the children’s waiting area from the adult section and no dedicated clinical cubicle or trolley space. Whilst one resus bay had been identified for the care of a child or young person we did not see where the décor around this bed space differed from that of an adult resus bay. Murals, mobiles, posters and colourful decoration help allay anxiety and make clinical assessment and treatments much easier for all concerned.

Patients we spoke with told us they had felt emotionally supported when this was required. However, we did not observe staff giving patients and/or their relatives support to cope emotionally with their care, treatment or condition. We observed the time staff spent with patients was limited because they were so busy and staffing numbers were insufficient to meet the demands of the service.

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored “about the same” as other trusts in 23 out of 24 relevant to caring. The trust scored “worse than” other trusts for one question which was “If you had any anxieties or fears about your condition or
treatment, did a doctor or nurse discuss them with you?”

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

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

We spoke with 15 patients (14 adults and one child) and six relatives during our inspection of the ED and 12 out of 15 patients told us they had been given enough information about their condition and/or treatment in a way that they could understand.
Patients also told us, they were told and understood what was going to happen to them during their patient journey.

We observed a number of patients with communication needs and did not see where staff used communication aids to help with communication. We were not assured therefore, those patients were sufficiently involved in their care and treatment.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

In response to the Royal College of Emergency Medicine (RCEM) report ‘How to achieve safe, sustainable care in our Emergency Departments’, a number of processes were being developed and implemented within the department.

The Emergency Department (ED) was working closely with commissioners and external stakeholders to implement an integrated streaming service. This was to ensure patients were directed to the correct location or service and to the correct person to manage their clinical needs.

A service level agreement was in place with the local NHS ambulance trust to provide continuing care of patients whilst awaiting handover to ED staff.

The department was working closely with NHS Improvement (NHSI) to review processes relating to patient safety, patient flow and workforce.

We observed all processes to be in their infancy and currently ineffective in meeting the needs of local people. We found there were significant handover delays for patients arriving by ambulance and whilst waiting to be handed over to staff there was no oversight by department staff of the patients presenting condition and any deterioration. There was significant overcrowding in the emergency department with patients frequently remaining in the department for over 12 hours. Nurse staffing levels and skill mix were not sufficient to meet the needs of patients and there was not a clear streaming and/or triage process in place for patients arriving at the front door of the department.

The layout of ED was not suitable for the number of admissions the service received. During our inspection we saw a number of occasions where there was significant overcrowding with patients remaining in the department for over 12 hours. Throughout our inspection we saw patients being cared for on trolleys in the central area as there were no free cubicles to use. Disabled toilet facilities were not available in the main ED but in the reception area only and we did not see where the environment was considerate to the needs of vulnerable patients for example, patients living with dementia.

Whilst there was adequate space and seating in the reception area for patients. The ED did not accommodate the needs of children, young people and accompanying families in line with the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings (2012). There was no audio and visual separation of the children’s waiting area from the adult section.

During our inspection, we were not made aware of, and did not observe, any systems or staff members in place to aid the delivery of care to patients in need of additional support. For example, dementia champions or use of dementia symbols or learning disability link nurses or alert stickers on patient records.

Signage to the department was clear and displayed in a number of different languages and there was a visual display in the waiting area advising patients of the length of time they could expect to wait to be seen.
A quiet area was available in the main ED where patients could wait if they found busy environments distressing. However, this was also used as a relative’s room and, at times, an assessment room for patients admitted with a mental health illness.

**Meeting people’s individual needs**

**Emergency Department Survey 2016**

The trust scored “about the same” as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

During our previous inspection in October 2016 we had identified the Emergency Department (ED) had not taken action to address the accessible information standard. From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the accessible information standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services.

At this inspection we saw there appeared to have been no action taken to address this standard. There was no hearing loop available at the reception desk, disabled toilet facilities were available in the waiting area only and we saw no leaflets or written information, available in any format, across the department. There was however ramped access to the ED to aid entry and exit for patients with mobility issues.

The ED did not take account of individual needs of patients living with dementia. With the exception of ‘twiddle muffs’ we did not see where the environment or additional care needs had been considered.

Extra support or supervision for vulnerable or agitated patients was provided by relatives or nursing staff. However, nursing staff shortages meant 1:1 supervision was not always provided. During our inspection we observed, on a number of occasions, where vulnerable patients were alone, upset and frequently calling for assistance.

Arrangements were in place for patients who needed interpreting services. Staff had access to an external interpreting service, 24 hours a day, seven days a week.

A telephone referral system was in place for staff to access one of two learning disability specialist nurses employed by a neighbouring mental health trust.

Chaplaincy services were available on the hospital site, for spiritual support for all patients, relatives, carers and staff regardless of whether they had any religion, belief or not. Chaplains were available Monday to Friday 9am to 5pm and Sunday 9am to 5pm. Out of hours there was two chaplains available on-call covering trust wide. Pilgrim hospital had a chapel which was
available at all times. Prayer room facilities were provided either in the chapel or elsewhere in the hospital.

**Access and flow**

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for any of the 12 month period from November 2016 to October 2017.

Performance against this standard showed a trend of slight improvement with the median wait time ranging from 67 minutes to 79 minutes over the time period.

**Ambulance – Time to treatment from November 2016 to October 2017 at United Lincolnshire Hospitals NHS Trust**

(\textit{Source: Source: NHS Digital - A&E quality indicators})

For the reporting period March 2017 to February 2018 the average time patients waited from time of arrival to receiving treatment at Pilgrim Hospital’s Emergency Department (ED) was a median of 75 minutes.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust breached the standard every month from December 2016 to November 2017. At the national level it was also seen that the standard was not met in any of the 12 months reported. However the trust’s performance was worse than the England average in all 12 months.

The trust’s performance against this metric remained similar between December 2016 and November 2017.
Four hour target performance - United Lincolnshire Hospitals NHS Trust

For the reporting period April 2017 to February 2018 the average percentage of patients admitted, transferred or discharged within four hours from Pilgrim Hospital's ED was 70%.

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From December 2016 to November 2017 United Lincolnshire Hospitals NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was better than the England average for the first six months. However, performance deteriorated month on month from May 2017 (8.3%) to November 2017 (22.7%) with the trust’s performance being worse than the England average from June 2017 onwards.

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - United Lincolnshire Hospitals NHS Trust


For the reporting period March 2017 to February 2018 the average percentage of patients waiting between four and 12 hours from the decision to admit until being admitted from Pilgrim Hospital’s
ED was an average of 15% 

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

Over the 12 months from December 2016 and November 2017, one patient waited more than 12 hours from the decision to admit until being admitted.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients over four hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-16</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>Jan-17</td>
<td>104</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>81</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>44</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>286</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>446</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>491</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>547</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>730</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>806</td>
<td>1</td>
</tr>
<tr>
<td>Nov-17</td>
<td>814</td>
<td>0</td>
</tr>
</tbody>
</table>

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

The trust provided us with data for the reporting period March 2017 to February 2018 the average number of patients waiting more than 12 hours from the decision to admit until being admitted at Pilgrim Hospital’s ED was zero.

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

From November 2016 to October 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average. The percentage of patients leaving before being seen ranged from 2.6% (April 2017 and October 2017) to 4.0% (August 2017). The England average ranged from 2.7% to 3.4%.
For the reporting period March 2017 to February 2018 the average percentage of patient that left the trust without being seen from Pilgrim Hospital’s ED was 2.9%

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

From November 2016 to October 2017 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average. Performance against this metric has remained similar over time with the median total time in A&E ranging from 167 minutes (April 2017) to 185 minutes (December 2016). The England median total time in A&E ranged from 144 minutes to 154 minutes.

**Median total time in A&E per patient - United Lincolnshire Hospitals NHS Trust**

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

For the reporting period March 2017 to February 2018 the average total time in A&E per patient
at Pilgrim Hospital’s ED was 200 minutes.

Operational pressures in the ED for example, increases in demand, were communicated using the Operational Pressures Escalation Levels (OPEL) framework. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for local A&E Delivery Boards and ensures an awareness of activity across local healthcare providers. Escalation levels ran from OPEL 1; The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources to, OPEL 4; Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. During our inspection the ED was consistently at OPEL 3-4.

An operational escalation policy was in place to support the ED in meeting variations within patient flow. At times where demand exceeded capacity a full capacity protocol was in place. Senior staff within the department were aware of both the policy and protocol and we saw actions taken that aligned to both.

An ED risk tool gave an “at a glance” look at the number of patients in the department, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building. However, despite OPEL scores of 3-4 the ED risk tool was not always updated appropriately.

A trust wide winter plan set out the trust’s arrangements for the winter period. Winter had been recognised as a period of increased pressure due to demand both in the clinical acuity of the patients and the capacity demands on resources within the trust. The winter plan prepared the trust, with support from health and care providers in Lincolnshire, to focus on admission avoidance schemes and ambulatory care pathways, creating the capacity to meet increased demand, link the trust winter plan to the Lincolnshire ‘System Resilience Plan’ and to performance manage the system to maintain quality, activity, safety and experience.

Operational flow (patient flow) through the hospital was managed by an operations centre. The operations centre acted as the hub for information regarding the daily management of patient flow. Bed meetings were held at 8:30am, 12:30pm and 3pm daily, further bed meetings were held if the hospital site was under extreme pressure (OPEL 4). Attendance at bed meetings followed the standard operating procedure for bed meetings but typically included; the site duty manager, bed manager, matron of ED and head of nursing. At times of extreme pressure additional staff were required to attend for example, the emergency physician in charge of ED.

Within the ED, two-hourly meetings took place between the nurse in charge and the emergency physician in charge to review all patients in the department in addition, a 3pm ‘huddle’ took place between the nurse in charge and all medical staff on duty. We attended the huddle and saw where a discussion took place of all patients in the ED as well as any safety issues within the department.

An ambulatory emergency care unit (AEC) was open from 8.30am to 10pm, Monday to Friday to provide a short period of observation, investigation or treatment to adults only. The unit had six beds and two seated areas. Patients were referred by their GPs or, if appropriate, transferred from the ED. However, at the time of our inspection the AEC was being used as an escalation area due to high capacity within the trust, we did not therefore, inspect this area.

Three rapid assessment and treatment (RAT) cubicles were available for the early assessment of ‘majors’ patients arriving by ambulance. The RAT process was carried out by a consultant, registered nurse and health care assistant. However, we saw the RAT process was ineffective at reducing ambulance handover times. Patients were waiting up to two hours before being clinically assessed by the RAT team.
Learning from complaints and concerns

Complaints relating to the Emergency Department (ED) were raised through the patient advice and liaison service (PALS). Staff were aware of their responsibilities to help patients to complain and would signpost patients to PALS. However, no posters or leaflets were visible to provide patients with this information.

None of the patients we spoke with had needed to complain about the ED. However, all of the patients said they would speak to one of the staff or the nurse in charge if they had any concerns.

Summary of complaints

From October 2016 to September 2017 there were 152 complaints about urgent and emergency care services. The trust took an average of 73 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 152 complaints, 117 had been closed at the time the data was provided and only 7.7% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days. Even when taking this target into consideration still only 21.4% of all of the closed complaints were closed within 50 days.

At Pilgrim Hospital there were 76 complaints. The trust took an average of 80 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 76 complaints, 54 had been closed at the time the data was provided and only 3.7% of these had been closed within 35 days. The trust has a further target to close 80% complex complaints within 50 days. Even when taking this target into consideration still only 7.4% of all of the closed complaints were closed within 50 days.

There were five complaints that were re-opened in the time period.

The most common themes complained about at Pilgrim Hospital were all related to delays. These were: delay or failure to diagnose (20), delay in undertaking tests (six) and delay in treatment (five). This reflects the most commonly reported serious incident type reported for urgent and emergency care at this hospital (diagnostic incident including delay meeting SI criteria).

(Submit: Routine Provider Information Request (RPIR) Complaints)

None of the staff we spoke with were able to give us examples of complaints received in the ED and none of the staff were able to tell us of where the outcome of a complaint had changed practice within the department.

Is the service well-led?

Leadership

The Emergency Department (ED) was part of the medicine directorate. The overall lead for the emergency department was the clinical director, who was supported by the head of service, head of nursing, matron, a general manager and a band seven nursing sister.

Leadership for mental health services within the department was provided by three 'mental health champions'; a consultant, staff nurse and support worker. Mental health champions were supported by staff from the nearby specialist mental health trust.

There were four band seven nursing sisters within the ED. An additional band seven had been moved over from Lincoln County Hospital to provide leadership support to the existing band seven leads.

Leadership within the department was not effective. Whilst leaders demonstrated an awareness of the challenges within the ED there did not appear to be one individual taking overall responsibility for the day to day running of the department and as such clinical practices appeared to vary depending on who was in charge on a given day. For example, the streaming process and the
process for recording triage times varied throughout our inspection as did the allocation of clinical staff at times of extreme pressure. Feedback from staff working in the department suggested there was no one consistent approach to care delivery.

Not all senior leaders had an awareness of Royal College of Emergency Medicine (RCEM) guidelines. RCEM guidelines are fundamental for professionals working in emergency medicine. Results and feedback from RCEM audits was not widely shared across the leadership team.

At the time of our inspection senior leaders were highly visible, and working clinically, within the department and front line staff described them as approachable. However, staff were less complimentary about the band seven leadership. Staff told us, they received little or no feedback following incidents or complaints raised, support following times of extreme pressure or an adverse event was minimal and the morale of the unit was dictated by who was in charge at the time. We observed, at times of high stress how the behaviour of leaders in the department changed, which had a negative impact on staff.

**Vision and strategy**

The trust vision; working together to provide sustainable high quality patient-centred care for the people of Lincolnshire was underpinned by five values; patient centred, safety, excellence, compassion and respect.

The vision and values had been included as part of an extended communications campaign that included engagement events, new contemporary visible brand identification for the trust and live social media events with staff.

To ensure values and vision were embedded the trust had launched a staff charter and personal responsibility framework. The staff charter set out clear expectations of what the trust expected to see from staff and what staff could expect from the trust as an employer. A personal responsibility framework supported and underpinned the charter’s values, giving examples of the behaviours the trust would wish to see and those the trust did not wish to see, in order to help the trust create a positive, caring working environment.

Based around the trust’s five core values, both the charter and personal responsibility framework were created for staff, by staff. None of the staff we spoke with, in the Emergency Department (ED), told us they had been involved in developing either the charter or the personal responsibility framework. However, all the staff we spoke with were aware of the vision and values of the organisation.

The trust’s ‘2021 Strategy’ set out how by working closely with local health and care partners, healthcare was to be delivered differently in order to provide more seamless care for patients. The 2021 strategy included the vision and values of the trust and had been developed in collaboration with staff, people who use services, and external partners. Staff understood what the strategy was, and recognised there were a number of changes occurring in the ED that aligned to this however, staff did not feel inclusive and felt they were told of changes rather than being included in them.

The trust vision and strategy was inclusive of mental health and we saw where developments within the ED around mental health were supportive of the vision and strategy and included for example, a mental health and learning disability strategy group.

**Culture**

Morale in the department was low, this was evident across both nursing and medical staff. Frustrations around leadership, low staffing, capacity and flow and the environment had led to a culture of acceptance with staff lacking the drive to challenge systems and processes within the department.

Front line staff did not feel supported, respected or valued by their immediate line manager(s). We were told there were inconsistencies in leadership skills and that staff often had to change the way they worked depending on who was in charge. Staff told us this left them feeling frustrated. Staff felt unable to suggest new ways of working to address times of extreme pressure within the department leaving them feeling undervalued.
Senior managers within the Emergency Department (ED) told us they were proud of their staff especially given the challenges staff faced on a day to day basis as a result of capacity and flow within the ED. Senior managers were aware that morale was low and the attitudes and behaviours of some staff was having a negative effect on patient experience. As a result, a group meeting between senior managers and front line staff had taken place to discuss and address concerns with a further meeting planned for after our inspection. However, front line staff we spoke with, told us they felt little had changed and where changes had occurred this had been done without their consultation.

Staff told us they were encouraged to report incidents but did not always do so appropriately. They described receiving little or no feedback from incidents and were not able to give us any examples of where the outcome of an incident had influenced or changed clinical practice within the department.

Consideration was given to patients’ mental health and emotional wellbeing needs in day to day activity within the service, for example, record keeping and care and treatment plans. However, we did not observe patients’ mental health and emotional wellbeing to be considered as part of the handover process.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were familiar with the duty of candour and the concepts of openness and transparency.

There was a ‘Being Open and Duty of Candour’ policy in place in the trust in addition to, ongoing work to finalise an electronic training package that was to go onto the electronic staffing system as a core training module. This was supported by a dedicated site for duty of candour on the trust intranet that was to include staff leaflets and promotional materials.

Mechanisms were in place for providing all staff at every level with the development they needed, including appraisals and career development conversations. We saw where recent developments included some band five nursing staff progressing to band six leadership roles and trainee nursing associate staff were working in the ED. The nursing associate role is a support role that sits alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients.

There were appropriate security arrangements in place to keep staff and others safe and protected from violence, including at weekends and out of hours. Staff told us the hospital security team were very responsive and described a good working relationship with the local police.

**Governance**

There were not effective structures, processes and systems of accountability in place to support the delivery of the trust’s strategy and good quality, sustainable services. Processes that had been developed and implemented within the department were in their infancy and currently ineffective in meeting the needs of local people. We were not assured therefore, patients were sufficiently protected from avoidable harm.

During our inspection we found there were significant handover delays for patients arriving by ambulance. Whilst waiting to be handed over to staff there was no oversight by department staff of the patients presenting condition and any deterioration. There was significant overcrowding in the emergency department with patients frequently remaining in the department for over 12 hours. Nurse staffing levels and skill mix were not sufficient to meet the needs of patients and there was not a clear streaming and/or triage process in place for patients arriving at the front door of the department.

We escalated our concerns to the trust’s executive team both during and following our inspection. The trust provided additional information to assure us of actions they were taking to protect patients from avoidable harm. However, we were not assured by the actions the trust had taken. Following our inspection we served an urgent Notice of Decision (NoD) under Section 31 of the
Health and Social Care Act 2008. The NoD was served as we found evidence to suggest the quality of health care required significant improvement.

Leadership within the Emergency Department (ED) was ineffective. At the time of our inspection there were four band seven nursing sisters in post. However, of these four, there was not anyone taking the lead or, assuming accountability for the day to day running of the department. Band seven’s appeared to be working in isolation rather than providing a consistent leadership approach for the remaining ED staff. An additional band seven nursing sister had been transferred across from the ED at Lincoln County Hospital to support the existing band sevens however, this support had only recently been introduced and as such it was too early for the inspection team to determine if this was having a positive effect on the department.

A service level agreement (SLA) was in place with the local NHS ambulance trust whereby ambulance crews had responsibility for patients until handed over to the trust, this included crews monitoring patients and should a patient deteriorate escalating appropriately to the nurse in charge. However, nursing staff and ambulance crew staff we spoke with were not aware of processes outlined in the SLA. We were not assured therefore, there were effective governance procedures in place for managing and monitoring this SLA.

An ‘urgent care streaming service’ (USCC) operated at the front door as an integrated service, with the ED delivering the initial streaming assessment and the local NHS community trust delivering the primary care element. However, during our inspection, we did not see a clear streaming process in place for patients. Patients were not seen in order of priority and the system did not allow early recognition of those patients who needed to be treated immediately in the majors or resus areas of the department. We were not assured therefore; appropriate joint governance arrangements were in place to consider the operation effectiveness of the streaming process.

The head of service was the sepsis lead and was responsible for overseeing sepsis management in the department.

Management of risk, issues and performance

The management of risks, issues and performance in the Emergency Department (ED) was not robust. Concerns identified by the inspection team such as, handover delays, overcrowding and poor staffing were not managed appropriately leading to poor patient experience and the risk of avoidable harm to patients.

Quality, safety and performance was discussed at a monthly speciality governance meeting which reported to monthly clinical directorate governance meetings. These meetings upwardly reported to the quality performance improvement committee which was chaired by the deputy chief executive. However, there was a disconnect between these meetings and the information front line staff received.

We did not see effective structures in place to ensure staff received appropriate and timely feedback from for example, incidents, complaints and performance data. Staff repeatedly told us they received little or no feedback and that departmental staff meetings did not take place. Senior managers told us this was because of staffing shortages within the department and that a communication book was in place to mitigate this. However, concerns we had identified, part-way through our inspection, had not been entered in the communication book for staff on duty the following day.

Senior leaders had little knowledge of national guidance and performance outcomes relevant to this department. One senior lead told us they were not from a urgent care background and another told us, they did not feel confident discussing audit results and action plans with us.

Audit participation was low in some areas. For example, the ED had not participated in a number of RCEM audits including for example; ‘Vital signs in children’ and ‘Procedural sedation in adults’, nor did we see evidence of any prescribing audits within the department. Senior leaders told us this was because of the low numbers of substantively employed medical staff within the ED. We
were not assured therefore senior leads, had sufficient oversight of performance in the department and were able to identify where action should be taken.

Effective arrangements were not in place for identifying, recording and managing risks. Concerns identified during this inspection relating to; nurse staffing levels, ambulance handover processes, the streaming process, the ongoing care of patients, registered paediatric nurses and agency nurse induction all posed a significant risk to patient safety. Despite senior leads demonstrating an awareness of our concerns, with the exception of nurse staffing levels, none had been recorded on the ED risk register.

The ED risk register dated 19 February 2018 identified five risks; medical staffing levels, patient safety/infrastructure, nursing vacancies, provision of a secure physical environment and risk to safety. Causes of the risk and impact on patients were identified in each case and controls were in place to manage the risk. However, controls to manage nursing vacancies were not robust, we did not see where agency nurse induction had been considered as a control.

The department did not participate in any audits that were related to (or referred) to mental health and emotional wellbeing. However, senior leads demonstrated to us a good awareness of the risks and issues related to mental health and emotional wellbeing. We observed significant actions had been taken following our last inspection and information received from the trust, following this inspection, showed where further actions were planned.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident. During our inspection, a group of staff were undertaking a major incident exercise. Staff told us these usually took place monthly however, as a result of staff shortages, they had not completed one since September 2017.

**Information management**

During this inspection, we were not assured senior leads had a holistic understanding of performance or quality. Whilst some audits were in place, audit participation was low and staff were not able to demonstrate where appropriate actions had been taken as a result of audit results. In addition, where audit results required an action plan these were not always submitted. For example, where cleaning audit results had been worse than the trust target for 11 out of 12 months action plans had not been submitted. We did not see where actions had been taken to address non-compliance.

An Emergency Department (ED) risk tool gave an “at a glance” look at the number of patients in the department, time to triage and first assessment, number of patients in resus, number of ambulance crews waiting and the longest ambulance crew wait. This gave a focus across the trust on where pressure was building. However, we observed this was not always updated appropriately.

Service performance measures were not always accurately completed. For example, as part of the safety and quality dashboard (SQD) the ED monitored the percentage number of patient triaged within 15 minutes. On the last day of our inspection we overheard two nurses discussing what time they needed to document as the triage time. The senior of the two nurses advised that the initial assessment time (streaming time) should be recorded. We were not assured of the accuracy of this figure.

Staff did not always have sufficient access to information. There were not robust procedures in place for feeding back learning from incidents, results of audit or results of the SQD. Policies and procedures were available on the trust’s intranet and in the department however, not all staff were aware of these. For example, a locum doctor was unaware of the policy for fractured neck of femur and most of the nursing staff were unaware of the trust risk assessment booklet despite there being an ample supply within the department.

Systems and processes were in place to ensure data and notifications were submitted to external bodies as required, for example serious incidents to both the Care Quality Commission and the commissioners of the service.
Patient identifiable information was managed appropriately. During our inspection we did not see any occasion when patient records with confidential information were left unattended. Notes from patients who had been discharged were kept securely at all times.

Senior staff members were required to report on any aspect of patients’ mental health or emotional wellbeing. A multi-agency case review system had been developed and introduced trust wide, to enable a reflective learning process to be undertaken following a mental health detention and to ensure policy had been followed; these were then presented to the mental health and learning disability strategy group.

**Engagement**

The Emergency Department (ED) gathered patient feedback through the A&E Friends and Family Test (FFT). FFT gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely they are to recommend the service to their friends and family if they needed similar care or treatment.

As part of the safety and quality dashboard (SQD) the ED monitored the percentage number of patients reporting good communication from staff and the number of formal complaints received was monitored monthly through the ‘ward health check’.

We did not see where patient’s views and experiences were gathered from those patients with illnesses relating to their mental health or emotional wellbeing.

Social media was used as a mechanism for engaging with staff in the department. However, staff told us they felt this was used inappropriately and gave a recent example where senior managers had changed a practice within the department and that they had been “told” rather than consulted, through social media.

Staff told us they did not feel engaged, able to raise concerns or, able to suggest new ways of working. None of the staff we spoke with were aware of the role of the ‘freedom to speak up guardian’. Senior managers felt they were engaging with staff and gave us an example of where they had met with staff to discuss their concerns. Minutes of the meeting were unavailable has staff had specifically requested they were to remain confidential.

The ED worked collaboratively with external partners to build a shared understanding of challenges within the system. This included; NHS Improvement (NHSI), commissioners, local NHS acute and community trusts and the local NHS ambulance trust.

**Learning, continuous improvement and innovation**

During this inspection we did not see evidence of continuous learning, improvement and innovation in the Emergency Department (ED). Whilst some improvements had been made since our last inspection we were not assured sufficient improvements had been made in order to protect patients from avoidable harm. The pace of change within the department appeared slow and whilst staff were clearly committed to providing a good safe service this was hindered by ineffective systems and processes, lack of adequate resources and poor leadership.

However, senior managers made us aware of significant developments within the ED that aligned to improved services for patients with mental health needs. For example, plans were in place to furbish the relative’s room to full Psychiatric Liaison Accreditation Network (PLAN) standards.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at the trust provides care and treatment for rehabilitation complex needs medicine (Elderly), cardiology, respiratory medicine, gastroenterology, general medicine and stroke medicine, clinical haematology, geriatric medicine as well as clinical oncology (previously radiotherapy).

There are 495 medical inpatient beds located across 24 wards.

Pilgrim Hospital Boston

<table>
<thead>
<tr>
<th>Location site name (CQC registered location)</th>
<th>Team/ward/satellite name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Hospital Boston</td>
<td>Acute Medical Unit</td>
</tr>
<tr>
<td></td>
<td>Ward 6A</td>
</tr>
<tr>
<td></td>
<td>Ward 6B</td>
</tr>
<tr>
<td></td>
<td>Ward 7A</td>
</tr>
<tr>
<td></td>
<td>Ward 7B</td>
</tr>
<tr>
<td></td>
<td>Ward 8A</td>
</tr>
<tr>
<td></td>
<td>Coronary Care Unit</td>
</tr>
<tr>
<td></td>
<td>9A (Stroke Unit)</td>
</tr>
</tbody>
</table>

Pilgrim Hospital in Boston has 191 beds located within eight wards.

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

From October 2016 to September 2017 the trust had 70,960 medical admissions. Emergency admissions accounted for 31,481 (44%), 37,660 (53%) were day case, and the remaining 1,819 (3%) were elective.

Admissions for the top three medical specialties were:

- General medicine, 27,484
- Clinical oncology (previously radiotherapy), 8,005
- Gastroenterology, 7,941

(Source: CQC Insight)

Between October 2016 to September 2017 medical specialties at this site treated 29,393 patients, which represented 36% of all medical patients treated in the trust.
**Is the service safe?**

**Mandatory training**

**Mandatory training completion rates**

The trust set a target of between 90 to 100% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical/dental and nursing staff in medicine is shown below:

**Pilgrim Hospital Boston – medical/dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>32</td>
<td>34</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>31</td>
<td>34</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>31</td>
<td>34</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>30</td>
<td>34</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>29</td>
<td>34</td>
<td>85%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>29</td>
<td>34</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>29</td>
<td>34</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>28</td>
<td>34</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>28</td>
<td>34</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>24</td>
<td>34</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>20</td>
<td>34</td>
<td>59%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>3</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

There were 13 training courses eligible for medical and dental staff of which the trust only met for the target for one module for equality, diversity and human rights. The trust did not meet the target for any other module, the lowest completion rate was 0% for medicine management training of which nine medical and dental staff were trained yet none were eligible for the module.

Last year the medical and dental staff for medicine did not meet the training completion rate, reaching 82% for the financial year April 2016 to March 2017.

**Pilgrim Hospital Boston - Qualified nursing & health visiting staff (Qualified nurses)**
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>181</td>
<td>185</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>169</td>
<td>185</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>167</td>
<td>185</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>163</td>
<td>185</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>161</td>
<td>185</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>160</td>
<td>185</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>159</td>
<td>185</td>
<td>86%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>142</td>
<td>185</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>135</td>
<td>185</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>131</td>
<td>185</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>99</td>
<td>185</td>
<td>54%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>82</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>27</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

There were 11 training courses eligible for qualified nursing staff of which the trust met for the target for three modules with the highest completion rate at 97% for equality, diversity and human rights.

Last year the qualified nursing staff for medicine met the 88% completion rate and is close to this completion rate for the date period April 2017 to October 2017 (84%).

- Pilgrim Hospital Boston had an 86% mandatory training completion rate.

(Source: Routine Provider Information Request (RPIR) – Training)

We spoke with the nurse in charge on each ward about mandatory training. In each case they told us protected time to complete this had improved recently but persistent short staffing meant staff were often unable to attend. The ward sister on the acute medical unit (AMU), with support from two clinical educators, had significantly improved training compliance of their team, from 71% in August 2017 to 93% in February 2018. The clinical educator on wards 6a and 6b had worked closely with nursing, healthcare assistant (HCA) and foundation level doctor teams to improve compliance with mandatory training.

**Safeguarding**

**Safeguarding training completion rates**
The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical/dental and nursing staff in medicine is shown below:

### Pilgrim - medical/dental

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>30</td>
<td>34</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>30</td>
<td>34</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>27</td>
<td>34</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>27</td>
<td>34</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff were eligible to complete four of the possible six safeguarding training modules set out by the trust for medicine, they did not meet the 90% target for any of the modules.

### Pilgrim Hospital - Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>169</td>
<td>185</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>168</td>
<td>185</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>158</td>
<td>185</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>156</td>
<td>185</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

There were four safeguarding modules eligible for qualified nursing staff of which the trust target met for the target for two modules.

- Pilgrim Hospital Boston had an 88% safeguarding training completion rate.

(Source: Routine Provider Information Request (RPIR) Training)

A safeguarding lead was in post and worked with safeguarding link staff on each ward to provide care for vulnerable patients. A safeguarding referrals pathway was in place, which staff used to assess patient needs and ensure the appropriate specialist team was engaged. Staff on ward 6b had prepared a safeguarding information board that aimed to increase awareness and understanding amongst the relatives and friends of vulnerable adults.

All of the staff we spoke with demonstrated a good standard of knowledge of safeguarding, including how to recognise signs of abuse and how to act on these. Staff were also knowledgeable.
on the action to take when they suspected or confirmed female genital mutilation (FGM) or when they had evidence of radicalisation in line with the government’s Prevent framework.

A safeguarding practitioner had delivered six training sessions to staff in the AMU following feedback that staff felt the trust’s mandatory training was too generic. After the more specialised training, nurses we spoke with said they felt much more confident in issues relating to safeguarding.

**Cleanliness, infection control and hygiene**

Between February 2017 and February 2018 the hospital reported one instance of methicillin-resistant Staphylococcus aureus (MRSA), four cases of methicillin-sensitive Staphylococcus aureus (MSSA) and 21 cases of *Clostridium difficile (C.Diff)* acquired on site.

A senior nurse carried out monthly decontamination audits in the endoscopy unit that involved members of the team. We looked at six examples of these audits and found evidence of consistently good practice with areas for improvement documented where necessary. For example in November 2017 a senior nurse instructed two healthcare assistants to carry out a scope decontamination audit that involved tracking the use of individual scopes. The team identified a need for engineer intervention in the timing monitors of washing and drying equipment and more consistent timely removal of scopes from the washer. Quarterly decontamination audits of endoscopic equipment took place in line with national standards and as required by Joint Advisory Group (JAG) accreditation guidelines. We reviewed the most recent two audits for 2017/18 and found an Authorising Engineer (Decontamination) had carried them out and found all practices to be satisfactory. They had also made appropriate recommendations to ensure audits were maintained. Decontamination supervisors were in post who maintained these standards.

The trust participated in the national patient-led assessment of the care environment (PLACE), which assessed wards and clinical environments against six criteria. In 2017 medical inpatient wards scored 96% in the assessment for cleanliness, which was similar to the 2016 score of 95%.

All of the clinical areas we inspected were visibly clean and during most of our observations we noted staff adhered to trust policy in relation to hand hygiene and the use of personal protective equipment (PPE). This included washing hands between patient contact and appropriate use of antibacterial gel. In addition we saw staff enforced the trust’s ‘bare below the elbows’ policy to reduce the risk of cross-infection. However on ward 7b we observed a junior doctor taking blood from a patient without PPE. We spoke with the nurse in charge about this who said they would discuss hospital standards with the doctor. On the stroke ward we observed staff serving hot food at lunch were not wearing PPE. We asked the serving staff about this and were told they could not wear aprons because the heat from the food warmer melted the plastic. In addition we observed staff carrying uncovered urine bottles through the ward adjacent to the food service.

Infection control audits took place on each ward on a monthly basis and the results were displayed on quality assurance noticeboards. However it was not evident this tool was used effectively to drive safer practice. For example the audit result for ward 8a in February 2018 indicated 92% compliance but staff said they did not have access to the results and were unable to confirm any areas for improvement. We looked at the most recent ward meeting minutes, which had indicated a need for improved adherence to the uniform policy, blood cultures and sharps management. This meeting had taken place in October 2017 but staff were unable to tell us if the infection control issues identified had been improved or whether the latest audit results were reflective of them. Staff on ward 7b had a more in depth understanding of their infection control performance and knew the results of the last three hand hygiene audits and the last two waste disposal audits as well as the actions they had taken towards improvement. On ward 9a the most recent infection
control audit found 86% compliance. The nurse in charge was unsure of the results or why the score was below trust standards and said they did not get feedback from the audit.

Short staffing in the housekeeping and HCA teams on ward 7b meant daily cleaning duties were sometimes delayed. This included the completion of morning scheduled cleaning and gaps in the completion of checklists.

Two nurses on ward 9a were completing an infection control course to improve standards on the ward. Although cleaning checklists were on display in the ward none of them had been signed or completed. We spoke with the nurse in charge about this who said engaging staff with infection control processes was a priority and had been challenging due to significant short staffing issues.

The ward sister on the AMU had introduced a new cleaning checklist and rota system that assigned individual housekeepers to specific rooms in the unit. This enabled each individual to take ownership of their area of work as a strategy to ensure standards remained consistently high.

**Environment and equipment**

Policies and processes were in place to ensure the safe management of healthcare waste, including hazardous waste, in line with the Department of Health, Health Technical Memorandum 07-01. We saw sharps handling, storage and disposal practices met the requirements of the Sharps Instruments in Healthcare Regulations 2013.

In 2017 medical inpatient wards scored 97% in the PLACE assessment criteria for condition, maintenance and appearance, which was an improvement from the 90% score achieved in 2016.

We saw pressure mattresses and bariatric equipment in use around the hospital and staff told us these were readily available when needed.

Each ward or clinical area had a resuscitation trolley with a defibrillator and other emergency medical equipment, including ligature cutters. Clinical areas additionally had an anaphylaxis kit and a biohazard spill kit. In all cases kits had tamper-proof seals with the last usage and check date documented. We checked each trolley and stock of equipment in every medical ward we visited; including daily signed checks to indicate staff had inspected equipment, medicines and disposables. We found staff had consistently documented these checks every day for the previous three months with no missing dates. However on ward 6a we found the resuscitation trolley had been without a face mask for six weeks. Staff had submitted an incident report regarding this and the nurse in charge was investigating. On ward 8a there were gaps in daily check signatures for the hypoglycaemia kit, which was not sealed. On ward 7b staff had signed to note they had checked the contents of the difficult airway trolley on eight dates in the previous month but the seal had not been broken. This meant they had not physically checked the contents of the trolley. On ward 9a the resuscitation trolley was not sealed although daily safety checks had been documented consistently.

A storage area in the acute cardiac unit (ACU) was incorrectly signed and the contents presented a risk. For example the storage room had a fire door and a notice instructed staff to keep it locked shut. The door was propped open and contained soiled laundry and non-clinical waste as well as sterile consumables. We found multiple single-use items had expired, including catheters, lead inducers and dressings. Some consumables were stored in boxes that were for other products and others had been combined from different batches with different expiry dates. This meant we were not assured patients were protected from the risks associated with out of date stock. Also on this unit we found used disposable gloves had been discarded on top of a trolley and a further two fire
doors were wedged open. We escalated this to the nurse in charge who told us they would address the issues.

The environment on ward 9a was cluttered and we found a multi-sex toilet being used for equipment storage although a sign was in place to state the area should not be used for storage. In addition used towels and flannels were in the sink and a used pad was on top of the waste bin, which presented an infection control risk. A linen trolley in the corridor was used to store body creams that were open but did not have a marked open date. Five items of equipment on this ward were overdue for servicing, including two hoists and a portable heater.

Although the hospital had experienced two recent fires, we were not assured that fire risk processes were up to date. For example on the sixth floor of the main building a fire action poster adjacent to the lifts provided instructions for staff, including the need to write down the names of staff taking on specific roles during an emergency. The poster instructed staff to use a dry-wipe pen attached but this was missing. In addition a bathroom on ward 9a was being used to store materials including cardboard but was not equipped with fire detection or a fire proof door. Mattresses and scales were stored in a corridor on this ward adjacent to an electrical cupboard and we found it common practice for fire doors to be wedged open throughout the hospital.

Assessing and responding to patient risk

Staff used national early warning scores (NEWS) to monitor medical deterioration. The trust monitored the correct completion of the clinical observations through a monthly audit. This established standards of care in each ward or clinical area against trust standards. Between November 2016 and October 2017 average compliance with all observations was 70%. This was an average figure and reflected a trajectory of improvement from 55% to 84%. Performance between individual wards also varied. The stroke ward 7a achieved or exceeded the trust standard of 90% for at last five months during this period and the chemotherapy suite met this for two months. The acute cardiology unit demonstrated a significant trend of improvement during this period, increasing compliance by 42%, to 91%, between December 2016 and October 2017. Ward 9a demonstrated the most significant need for improvement, with 66% overall compliance from November 2016 to October 2017. Although there were month-on-month improvements within this period these were not consistent or sustained. We found consistent completion of NEWS observations in all areas during our inspection.

Serious incident investigations in 2017 indicated significant inconsistencies in the quality and standards of patient records. This included inconsistent care planning and a failure to document assessments for wound management, waterlow scores and a range of risk assessments.

During our inspection we reviewed a sample of 28 patient records across all wards. We found standards of risk assessments to be consistently good with fully completed and updated falls risk assessments, body mapping as part of the SSKIN bundle and nutrition and frailty risk assessments. On the stroke unit we found staff had clearly documented the use of all medical devices, including the tracing details for single-use items as well as clear treatment plans following ward rounds. Each record also included up to date risk assessments, patient demographic details and evidence of regular visual infusion phlebitis (VIP) scores.

Patients with an increasing NEWS score, which represented deterioration of their condition, were identified automatically on the electronic patient monitoring system. This system alerted the Critical Care Outreach Team (CCOT) as an escalation of care who then attended to the patient as a priority. Overnight the system alerted the site practitioner and hospital at night coordination.
centre. This team then identified the most appropriate clinician to assess the patient, such as the CCOT nurse or duty registrar.

The trust participated in a commissioning for quality and innovation framework (CQUIN) for sepsis screening as part of an action plan and programme to improve the monitoring of deteriorating patients. Beginning in July 2017 the trust reviewed 20 inpatients per month that received a positive sepsis result from a screen and identified their treatment against national sepsis standards. This meant the CQUIN identified whether patients received a screen within 60 minutes and whether they received antibiotics within 60 minutes. Between June 2017 and January 2018 the compliance rate with screening and treatment standards was 62%. This was significantly below the trust’s target of 90%. This was an overall average figure and reflected a range from 45% to 80%. The hospital did not meet the 90% standard in any month during this period. Performance for screening within 60 minutes between October 2017 and January 2018 was 74%, which was similar to the 77% of patients who received antibiotics within 60 minutes. During our inspection we reviewed a sample of 10 patient records where the individual had scored above the NEWS trigger point for a sepsis screen, representing a total of 20 instances in which a sepsis screen should have taken place. Staff had completed and documented a sepsis screen in a timely manner in 17 (85%) cases.

A sepsis practitioner post had been implemented as part of the trust’s quality improvement plan and had established sepsis care bundles that were monitored as part of the safety and quality dashboard monitoring system. They had delivered nurse training for antibiotics management and patients diagnosed with diabetic ketoacidosis (DKA) were ‘cohorted’ on ward 8a, which meant staff could more readily deliver specialised care in a smaller area.

The ward sister on the AMU had implemented a sepsis strategy that significantly improved screening rates. In August 2017 30% of patients whose condition should have triggered a sepsis screen received one. The ward sister investigated this and found 33 missed opportunities for screening, of which 30 were not escalated by HCAs. To address this they temporarily stopped HCAs from carrying out sepsis screening until they could undertake more training and worked with nurses to ensure patients were monitored appropriately. In February 2018 82% of indicated patients underwent a sepsis screen.

The investigation of a serious incident in January 2017 that resulted in the death of a patient noted the medical team had failed to act to help a deteriorating patient despite them being escalated through the site team and critical care outreach team (CCOT). There had also been poor adherence to process in the handover of an acutely unwell patient out of hours that was not identified due to substandard ward round processes and a failure of the medical team to follow policy. The clinical director implemented an action plan following this incident, which included improved documentation and management of patient risks.

During our observations of handovers we noted staff reviewed risk assessments and NEWS scores in detail and confirmed that the correct care pathways were in place. For example we observed a ward round team on ward 7b discuss the management of a patient who was deteriorating in relation to a worsening acute kidney injury. The team carried out a review of the patient’s medical history and liaised immediately with the multidisciplinary team.

Although staff demonstrated a proactive response to patients who deteriorated, we were not assured processes were in place for patients with complex medical and mental health needs. For example, where a patient was admitted with a history of depression and had refused critically important prescribed medicine for five days, there was very limited evidence staff had carried out appropriate risk assessments. We escalated this to the ward manager who said they would refer
the patient to the mental health team. We were not able to establish why this had not already been completed.

Medical patients were sometimes cared for as outliers on surgical wards, when medical wards were operating at capacity. We observed inconsistent practice in relation to risk assessments and monitoring of medical patients. Staff based on these wards said they did not usually know which doctor was responsible for which patient, which could cause delays in accessing help when needed. The nurse in charge of each ward escalated patients to the matron if they had not been reviewed by a doctor by 12pm each day but told us cover was unpredictable. For example, a patient on the ward had gone without a medical review for three days despite receiving IV antibiotics. This was inconsistent with information given to us by the medicine directorate leadership team who told us clinicians saw outlier patients before other patients.

The nurse in charge on the stroke ward carried out a daily morning safety huddle to identify issues and challenges on the unit. However short staffing affected this and on one day of our inspection the huddle did not take place due to the absence of three planned nurses.

Consultants were available seven days a week, which meant patients were seen within 14 hours by a senior clinician in line with the London Quality Standards.

Critical care beds with full ventilator support were available on site.

There were care pathways in place for patients seen in the endoscopy unit or in radiology who were unwell and needed admission.

From looking at patient records we saw completed appropriate risk assessments and risk management plans for patients receiving non-invasive ventilation and tracheostomy care.

**Nurse staffing**

The trust has reported their staffing numbers below for the period October 2017 for medicine. There are 122 less nursing staff in place (at trust level) within the medicine core service than was planned to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim</td>
<td>214.55</td>
<td>159.34</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 18.7% in medicine; the target for the trust was 11.5% for registered nurses and midwives

- Pilgrim Hospital Boston: 25%

(Source: Routine Provider Information Request (RPIR) Vacancy)

This was an average figure for all medical inpatient wards and we found some services were significantly affected by vacancies. For example the stroke unit had a 43% vacancy rate for staff nurses, a 50% vacancy rate for band four assistants and a 30% vacancy rate for band two healthcare assistants.

**Turnover rates**
From November 2016 to October 2017, the trust had a turnover rate of 8.3% in medicine; compared to the trust target of 7% and no staff group more than 20% above the target.

- Pilgrim Hospital Boston: 8.9%

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

Sickness rates

From October 2016 to September 2017, the trust reported a sickness rate of 5.28% in medicine; compared to the trust target of 4.5%

- Pilgrim Hospital Boston: 4.7%

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

Bank and agency staff usage

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 20.3% with a further 4.8% of shift remaining unfilled. A breakdown by staff type and location is shown below:

**Pilgrim Hospital Boston**

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>6,378 (14.9%)</td>
<td>1,701 (4.0%)</td>
<td>1,835 (4.3%)</td>
<td>42,884</td>
</tr>
<tr>
<td>Unregistered</td>
<td>2</td>
<td>5,753 (25.4%)</td>
<td>1,380 (6.1%)</td>
<td>22,674</td>
</tr>
</tbody>
</table>

From December 2016 to November 2017 the trust reported a bank and agency usage within medicine as below:

- Pilgrim Hospital Boston had a total of 14,541 shifts, agency covered 5,448 and bank staff covered 6,167 as well as 2,926 not covered at all.

(Source: Routine Provider Information Request (RPIR) Nursing bank agency)

Our conversations with patients and relatives reflected on the working culture of the hospital as patients described engaged teams but noted they often felt worried by how busy and rushed staff were. For example one patient in the acute medical unit (AMU) said, “Everyone is so nice but they are run ragged. I felt bad asking them even where the toilet was they were running about so much.” One patient on the ACU said, “It’s chaotic. Everyone seems so stressed but they never let this show in their care. Everyone is fantastic it’s just worrying to see them so stressed.”

Nurses in the endoscopy unit carried out two sets of observations once patients were moved to the recovery area after their procedure. This included the removal of cannulas and tolerance of a drink.

Agency nurses completed a comprehensive, documented induction before they were able to practice on the wards and take responsibility for individual patients. Agency nurses were also required to provide evidence of competencies or certification for administering intravenous medicine and complete an assessed observation by the ward sister or matron. The matron for
each clinical area audited the completion of agency nurse induction checklists on a quarterly basis and cross-referenced this with the information held by the temporary staffing team. We looked at a sample of 13 agency nurse checklists across five wards and found them to be fully completed with evidence of initial supervision by the nurse in charge. However, the investigation into a serious incident in 2017 found that agency nurses may not have up to date understanding of fire safety procedures despite this being an integral part of the induction.

Short staffing on wards 6a and 6b meant the nurse in charge regularly was not able to be supernumerary on every shift and was required to take patients. This meant they were unable to complete routine leadership tasks and had to do so in their own time.

Although the site team had a commissioned post for a member of staff dedicated to staffing issues on each shift, there was evidence of consistent instability amongst the nursing team. For example, during one bed meeting we found the afternoon shift in the hospital was short of 13 qualified nurses and eight HCAs. Although contingency plans tried to limit the safety impact of this, including virtual ward rounds and the cancellation of some surgical procedures, there was an ongoing impact on the operation of wards. On one day of our inspection ward 8a was operating with 50% of the planned nursing and HCA staff. This meant the nurse to patient ratio was 1:14.5.

Wards 3a and 3b were surgical wards and regularly provided care for medical patients as outliers during periods of high demand on the hospital. We spoke with the nurse in charge on one day of our inspection who said they always requested additional nurses on each shift where medical patients were being cared for.

The ward sister on AMU had introduced a new twilight shift to provide an additional nurse during a very busy time of day. However, 50% of the twilight shift nurses were moved from the AMU to an inpatient ward to provide cover in December 2017. This meant they were unable to provide the additional support they were in post to deliver.

**Medical staffing**

The trust has reported their staffing numbers below for the period October 2017 for medicine. There are 43 less medical staff in place within the medicine core service then was planned to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim</td>
<td>74.00</td>
<td>61.00</td>
</tr>
<tr>
<td>Total (trust)</td>
<td>243.76</td>
<td>199.97</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 16.8% in medicine; against a target of 12% for medical staff

- Pilgrim Hospital Boston: 10.9%

(Source: Routine Provider Information Request (RPIR) Vacancy)
Turnover rates

From November 2016 to October 2017, the trust a turnover rate of 8.3% in medicine; compared to the trust target of 7% and no staff group more than 20% above the target.

- Pilgrim Hospital Boston: 21.5%

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

Sickness rates

From October 2016 to September 2017, the trust reported a sickness rate of 2.59% in medicine; compared to a trust target of 4.5%.

- Pilgrim Hospital Boston: 1.3%

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

Staffing skill mix

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

Staffing skill mix for the 210 whole time equivalent staff working in medicine at United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</td>
<td>23%</td>
</tr>
</tbody>
</table>

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

Source: NHS Digital - Workforce statistics (01/08/2017 - 31/08/2017)

The respiratory team had two full time consultant vacancies, representing 50% of the establishment needed. However respiratory trainee doctors said they were well supported and up to date with training. The vacancy rate meant they sometimes found it difficult to get advice but they felt the specialty had a “community feel” to it that enabled everyone to support each other.

A team of five elderly care consultants led the specialty and provided on-site cover 24-hours from Monday to Friday. A consultant was on site from 9am to 9pm at weekends. In addition a chest physician, an endocrinologist, a cardiologist, five elderly care doctors and four acute physicians provided daily patient review.
A team of 13 oncologists provided care and treatment on the haematology-oncology ward and for chemotherapy patients. This team worked trust-wide and provided scheduled cover at this site. Each week a named consultant provided dedicated ward cover along with specialist registrars.

Medical care in the AMU was consultant-led and the medical team included 24-hour specialist registrar cover in addition to core trainees and foundation level doctors. We spoke with two doctors who said they felt well supported by the registrars and consultants and had always felt the unit provided safe care despite how busy it could get. Overnight cover was led by a senior house officer for inpatient medical wards and a senior house officer dedicated to patient referrals and admissions on the AMU.

A team of four consultants led medical care on the acute cardiac unit (ACU) Monday to Friday and a team of five specialist registrars worked between this site and two other hospitals in the trust. Out of hours on-site medical cover for cardiology was in high demand and was provided by one registrar. We spoke with registrars about this who said the on-call system was very challenging. This was because they covered the ACU as well as cardiology patients in the medical wards and on the AMU. They said this meant only the most acutely unwell patients could get a medical review overnight. One doctor described a situation in which 15 patients had been admitted before 9pm followed by another 15 overnight through the emergency department (ED). One patient died in the ED, which resulted in an incident investigation and a complaint. Staff told us this was as a result of low levels of out of hours cover and a high demand on the service. Although a consultant was on call from 5pm to 9am, one member of staff described this as “overwhelming” and another told us they felt safety standards were halved overnight. Two other doctors told us there was a culture that discouraged calling consultants out of hours, which contributed to junior doctors struggling overnight.

Wards 5a and 5b were sometimes used to accommodate medical outlier patients. A named consultant was responsible for these patients, which represented an improvement to the previous staffing cover arrangements. In addition a locum junior doctor provided additional support during the winter pressures period. Although an established escalation process was in place for outlier patients who deteriorated overnight, there was no equivalent standard operating process in place for patients at a weekend.

As part of our inspection we observed a medical handover on the AMU and saw this included a consistent focus on planned, safe discharge as well as a review of each patient’s multidisciplinary needs. Where inpatient areas had been unable to admit patients overnight due to pressures on staffing or capacity, the AMU team demonstrated how they maintained their needs until they could be admitted. For example one patient was due to be admitted to the critical care unit but the intensive care team had been unable to admit them overnight. As a result the AMU team provided treatment for sepsis and provided clinical care to meet their needs until they could be transferred. The AMU environment was very busy and meant patients could be admitted to the unit whilst doctors were in the handover process. A system was in place to ensure these patients were reviewed by the medical team after the handover process.

Overnight a medical registrar and an emergency care registrar provided cover in the hospital in addition to a senior house officer. However ward staff told us it was very difficult to obtain a doctor’s review overnight. One senior nurse said their team regularly put out an emergency call to get support from the site team because the doctors were too busy in the emergency department to assist.
Records

Patient notes were paper-based and stored in trollies on wards and outside of bed bays. In most areas these were unsecured and not continuously monitored, which meant unauthorised people could gain access to confidential information.

The trust carried out two audits on patient records in 2017 to establish compliance and standards against 36 standards set by the NHS Litigation Authority and using the Academy of Royal College record keeping tool. Medical inpatient services and the stroke service were audited twice and the AMU was audited once. Overall results were highly variable although there was evidence of improvements in some areas as a result of the audits. None of the clinical areas achieved the trust minimum standard of documenting the patient’s NHS number and their first and last names on every page of their record. Performance in this measure was significantly below standard in the stroke service, which demonstrated 61% compliance in the second audit. This represented score 32% worse than in the first audit.

The audits found a deterioration of standards in medical care for eight measures between audits including a 15% decrease in the patient records with times of entry recorded and a 30% decrease in full documentation about the prescribing of antibiotics. In the stroke service, legibility for the issuing of prescriptions and documentation of antibiotics both decreased by 50%. Deterioration was noted in some essential and basic elements of patient records, such as an 11% decrease in the number of patients with both their first and last names recorded. Medical wards improved standards in five measures between audits and the stroke service improved in two measures. In each audit services achieved the target of 100% in between eight measures and 15 measures. All services achieved 100% of the trust standards for seven total measures in all of the audits, including in the documentation of patient’s ‘do not attempt resuscitation’ (DNAR) status and clear recording of referrals and investigations.

The auditor made 11 recommendations following both audit cycles. This included wider publication of record keeping standards and requirements, sharing of results between specialties and the implementation of a trust action plan to improve overall compliance. In addition the auditor recommended records for patients receiving vascular care be moved to a specialist, separate audit.

We reviewed the records of three medical outlier patients who were being cared for on ward 3b, an orthopaedic ward. Each patient had received an initial assessment by a senior doctor or consultant within 24 hours of admission and every day of admission thereafter. Although there was evidence of a referral to the learning disabilities lead for one patient there was no evidence they had assessed the patient although ward staff told us this had taken place. We also reviewed the records for five medical outliers on ward 5b, a surgical ward. Although the same standards of consultant or doctor review applied, none of the patients had been seen by a doctor over the weekend. This included one patient who was admitted on a Saturday and was not reviewed by a doctor until 48 hours later. We spoke with the medical directorate leadership team about this who told us a consultant was available at the weekend for outlier patients but the ward staff had to request a review for them to attend the patient.

Although the overall standard of risk assessments and documentation completed by medical and nursing teams was of a high standard we found where locum consultants led care there were some gaps. For example on ward 7b we found a locum consultant was unfamiliar with the needs of patients on the unit although a foundation level doctor was supporting them. In addition one patient with complex needs had an incomplete ‘BOMB’ (background, observe, management, bring on the renal time) assessment.
Medicines

The pharmacy service to the wards was described as under pressure from staffing shortages; this meant all wards did have a pharmacist and a technician daily but this sometimes slipped when staff were not available. We were told that seven day working had reduced weekly pharmacy staff on the wards as staff who worked mornings on Saturdays and Sundays in the dispensary had a day off during the week and those wards they normally covered were not comprehensively covered by the team.

We found medicines held in the clinic rooms and the controlled drug (CD) cupboards for some time after patients were no longer on the wards. This led to overcrowding in the CD cupboards and meant that staff had more medicines than necessary to stock count on a daily basis increasing the risk of errors.

The use of the over-labelled medicines had reduced delays in obtaining to take away prescriptions (TTOs) although prescription charts still left the ward when there was no pharmacist available to authorise obtaining a new medicine or TTO.

On ward 9a we found that the fridge temperature had been recorded as being below two degrees centigrade on three occasions in February 2018 and on six occasions in January 2018 – we saw no documentation to support any actions having been taken in line with the trust policy for storage of refrigerated items. This may have impaired the efficacy of the medicines held within the fridge.

We examined medicines charts for 18 patients and identified that antibiotics were being managed appropriately, patient’s allergies were correctly identified and red wrist bands were in use. We saw evidence of venous thromboembolism (VTE) assessments being undertaken and responded to with prophylaxis prescribed where indicated.

From the 18 charts we identified seventeen medicines with no signature or code against the administration on one or more occasions. Therefore records could not assure us that patients received their medicines as prescribed and this included some critical medicines such as anticoagulants, a Parkinson’s disease medicine, analgesia, an antibiotic and one incidence for insulin.

We reviewed medicine storage and safety processes in all of the clinical areas we included in our inspection. This included the locked storage of controlled drugs (CDs) with restricted access and daily documented checks of stock signed by two nurses.

We checked the storage and documentation of CDs that patients brought with them when they were admitted. We found they were stored in locked bedside cabinets and the nurse responsible for the patient kept the keys for this. We saw two members of staff had signed for each administration of a CD and stock was correct in all six cases we checked.

We noted on ward 7b a patient had a missed dose of insulin and there was no documented reason for this and no incident report had been submitted. We spoke with the nurse in charge about this who submitted an incident report, which would trigger an investigation.

Improvements had been made to the system used for medicines management when patients were admitted to an inpatient ward from the AMU. For example the divisional leadership team told us there had been previous instances of stock discrepancies with regards to medicines on the AMU as well as prescribed medicines that were not transferred with the patient to an inpatient ward. The new system addressed these issues through an audit of antibiotics, anticoagulation medicine and medicines for Parkinson’s disease.
The ward sister on AMU had introduced a new ‘individual staff assurance record’ for medicines management safety. This followed an incident in which a check of controlled drugs was missed when one member of their staff was covering the theatre escalation area. The assurance record meant staff had a checklist to use to ensure they carried out medicine safety checks.

**Incidents**

**Never Events**

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

From December 2016 to November 2017, the trust reported one incident classified as a never event for medicine.

This never event took place in August 2017 at the Pilgrim Hospital Boston site, and related to a lumbar puncture on the wrong patient on the Acute Medical Unit.

![Incident Graph](source: NHS Improvement - STEIS (01/12/2016 - 30/11/2017)

Staff in all areas and at all levels of responsibility demonstrated understanding of the incident-reporting procedure and were able to explain what constituted a reportable incident.

All of the staff we spoke with in the AMU demonstrated detailed knowledge of the never event and learning that resulted from the investigation. For example doctors had improved communication standards with the nurse in charge and now referred to patients by name instead of by NHS number.

A further never event had taken place after this data was submitted. This related to an endoscopic procedure in which an incorrect orifice was used for a scope entry on the Lincoln site. As a result the team had improved care plans to include new labelling and more identifiable information regarding the planned procedure. All of the staff we spoke with in this unit demonstrated a detailed knowledge of the never event and of the learning as a result of immediate actions.

In addition the trust reported a never event that related to a patient death as a result of a misplaced nasogastric (NG) feeding tube. This was an avoidable event had staff had appropriate training and competencies. Following this the trust implemented a substantive improvement programme. This included new staff competencies and restrictions on who could insert, manage and monitor NG tubes. They also carried out a rapid review of all national guidance and standards for the use of NG tubes to provide assurance their policies reflected these. In addition quality matrons were establishing a new audit process to ensure the practice of using NG tubes was continually monitored. On the respiratory ward two nurses had completed the new training
and the ward sister told us there were no scheduled dates for the rest of the team. At the time of our inspection NG tube insertion was restricted to doctors whilst the quality matron and clinical educator teams embedded new standards of competencies. We saw new care bundle documentation was included in each patient’s record where an NG tube was in place. Although there was evidence of positive improvements following the never event, we were not assured the leadership team had addressed the issue of agency staff training and competency. For example the divisional leadership team did not know if agency staff had a competency check on their knowledge of NG feeding as part of their induction.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 137 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2016 to November 2017.

Of these, the most common types of incident reported were:

- Pressure ulcer meeting SI criteria with 50 (37% of total incidents).
- Slips/trips/falls meeting SI criteria with 30 (21% of total incidents).
- Treatment delay meeting SI criteria with 19 (13% of total incidents).
- All other categories with 15 (12% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 12 (9% of total incidents).
- HCAI/Infection control incident meeting SI criteria with 11 (9% of total incidents).

Site specific information can be found below:

- Pilgrim Hospital Boston: 77 incidents

(Source: Strategic Executive Information System (STEIS))

We reviewed the investigations of 25 SIs reported in medical care at Pilgrim Hospital and found an appropriate senior member of the clinical team had carried out a root cause analysis for each that included a timeline of key events. This enabled the senior team to identify how situations developed and what could have been done at each stage to prevent it. Each root cause analysis resulted in an action plan that incorporated the multidisciplinary team. For example the outcome of one SI identified a need for improved competency checks and training for nurses in the use of peripherally inserted central catheter (PICC) lines. Subsequently a vascular nurse practitioner introduced a competency workbook that nursing staff completed. Another SI investigation identified a need for more comprehensive nurse training on sepsis management and a significantly improved ward round process on ward 7b. We saw in each case a senior member of the clinical team had entered a timeline for improvements according to the action plan. Although in all cases action plans were detailed and appropriate based on the root cause analysis, there was not consistent evidence actions were monitored to completion and used to embed service improvements. For example, multiple incidents involved similar themes of a failure to follow established policy, missed opportunities for intervention and poor record-keeping. Our sample occurred over a 12 month period and it was notable that learning had not demonstrably improved care and treatment across medical services.

Consultants in each specialty reviewed morbidity and mortality on a monthly basis as part of clinical governance and safety assurance meetings. This had led to an increase in consultant cover at weekends, including in care of the elderly services, as a strategy to reduce mortality.

We received variable feedback about communication with staff after they had submitted an incident report. For example the individual submitting the report always received an automatic acknowledgement but some staff said they did not usually receive any specific feedback.
Safety thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported 61 new pressure ulcers, 71 falls with harm and 11 new urinary tract infections in patients with a catheter from December 2016 to December 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at United Lincolnshire Hospitals NHS Trust

![Graph showing prevalence rate of pressure ulcers, falls, and CUTIs]

(Source: Safety thermometer - Safety Thermometer)

Each ward used a safety and quality noticeboard to indicate their track record of operating without a hospital-acquired pressure ulcer (HAPU). For example staff on wards 6a and 6b had not reported a HAPU for over 132 days and the ACU had not had a HAPU for over one year. Where wards had experienced HAPUs or a falls incident, this was displayed along with the action taken. On this ward staff had implemented a falls reduction safety programme that included improved training for staff that enabled nurses and HCAs to more clearly identify risk. The team had implemented strategies such as adapting positions for patients from which they could take blood pressure readings.
Safety and quality dashboard data for the AMU indicated low levels of compliance with catheter care documentation. For example, August 2017 and October 2017 a catheter care record was completed in an average of 52% of cases. In August 2017 and September 2017 none of the catheter care records had been signed by a member of staff and in October 2017 40% of records had been signed. A catheter care committee was working to improve standards in this area and had relaunched a catheter care link nurse post and delivered catheter care training sessions.

**Is the service effective?**

**Evidence-based care and treatment**

Care and treatment pathways and policies regarding specific types of treatment were based on national best practice guidance and standards. For example, the policy for initiating non-invasive ventilation (NIV) was based on clinical guidance from the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians (RCP) and the British Thoracic Society. In addition, staff used national guidance to ensure their assessments reflected a holistic approach that included physical, mental, and social needs in addition to their presenting health complaint.

Recent improvements in the hospital’s capacity to accommodate patients who needed non-invasive ventilation (NIV) included an increase from two beds to four beds, new staff competencies, and oversight from a cross-site NIV committee. We saw staff adhered to national best practice when delivering NIV treatment.

The trust benchmarked assessments and prescribing for venous thromboembolism (VTE) against NICE clinical guidance 92 and used an auditing and quality governance process to identify areas of good performance and areas for improvement. Audits took place in two cycles twice each year and assessed care and treatment of patients against 12 criteria. The most recent results were published in March 2018 and found overall compliance to be 68% in both cycles. These were average figures and reflected a wide range in performance in each measure from 20% to 100%. Overall 93% of patients had a VTE risk assessment completed on admission and completed appropriately, and 50% of patients were reassessed by a senior clinician within 24 hours. In 100% of cases, pharmacological prophylaxis was prescribed in line with national guidance and was given as prescribed in 92% of cases. The key improvements identified from the latest results noted a need to implement more timely re-audits and actions based on the plan, do, study, act (PDSA) cycle. The audit leads had begun work to act on these results.

Therapies teams led audits specific to each specialty. In 2017/18 the audit plan reflected a range of audits to benchmark care and treatment against national quality standards as well as to understand and improve patient experience and outcomes. This included five occupational therapy audits, four physiotherapy audits, and one dietetics audit. Audits to benchmark care included for hip fracture treatment and osteoarthritis treatment, both in line with NICE guidance. To improve patient assessment and care, a dietician was leading an audit of specific textured diets and an occupational therapist was developing an amputee pathway.

The root cause analyses of serious incident investigations indicated a need for significantly improved staff adherence to trust policies and national care standards. For example, serious incidents had occurred where staff had not followed policies relating to sepsis, falls risk management, wound management, and observations of the deteriorating patients. Each investigation noted that the investigator had spoken with staff in the relevant clinical area, who demonstrated understanding of each policy and how to access it. The investigations did not clearly identify why this had not occurred in each incident although action plans indicated clear steps for accountable individuals to take.
In 2017/18 there were 38 active audits in medical care services made up of 21 national audits, 13 local audits and four corporate audits. The audit programme reflected contribution to a significant range of national benchmarking and accreditation bodies. The programme also represented the hospital’s drive to continue improving care standards and outcomes through practice that represented the latest knowledge on the specialty. Local audits were representative of the needs of the local population. For example one audit was in place as part of a nursing residential care home project and another was being used to improve adherence to the care bundle for chronic obstructive pulmonary disease.

The endoscopy unit was accredited by the Joint Advisory Group (JAG) for GI Endoscopy. This meant care, treatment and procedures were had been assessed to be delivered in line with international best practice standards and were regularly assessed and audited. The accreditation was an indicator of high quality performance and standards in line with those set by the international global ratings scale. A gastrointestinal (GI) bleed rota was in place as part of the joint protocols for emergency endoscopy, which the trust had implemented as a result of a previous serious incident. The rota was led by a gastroenterologist with support from a surgeon, junior doctors on a training rota, five nurse endoscopists and two trainees.

Staff assessed policies and audits before and during implementation to ensure they would not be discriminatory to staff, patients or other stakeholders with regards to the protected characteristics of the Equality Act. During our discussions with staff it was evident they had a good understanding of how to deliver care and treatment regardless of a patient’s personal identity or individual preferences.

**Nutrition and hydration**

A trust lead dietician led a team of eight dieticians, two dietetic assistants and a diabetes specialist. Specialist teams were also in place for neuro-rehabilitation and community nutritional support and a mental health specialist dietician was available for support from another NHS trust.

A community and home enteral nutrition specialist worked within the dietetics team to provide continuity of care after patients were discharged.

The dietetics team had broadened the criteria for providing care to patients who had experienced a stroke, based on the malnutrition universal scoring tool (MUST). Between August 2017 and November 2017 77% of patients had been screened for their nutritional needs and been seen a by a dietician, compared to the national average of 81%.

Staff on each ward used the MUST to assess and monitor patient’s nutritional needs. Where a MUST score indicated a risk of malnutrition, ward staff made a referral to a dietician. This team provided advice and support in relation to nutritional supplements and the occupational therapy team worked with them to provide equipment that could assist patients during mealtimes. However, we found inconsistent completion of food and fluid charts in some areas, including in ward 8a where staff had not always totalled daily fluid intake charts. Five ward sisters told us improving the completion of food and fluid charts was a key priority for them and this was noted on their safety and quality dashboard.

In the 2017 national patient-led assessment of the care environment (PLACE), inpatient medical wards scored 93% for food and hydration, which was a significant improvement from the 75% score achieved in the 2016 PLACE results.

In an effort to improve mealtime routines, staff on ward 6b had established a bell system to help patients prepare for lunch and dinner. This meant staff rang a bell to notify patients 20 minutes and 10 minutes before the meal service began.
Some members of the medical team on the AMU recognised that pressures on the nursing team meant there were frequent gaps in observations and recording, specifically in relation to the strict recording of fluid input and output for acute kidney injuries. The quality and safety dashboard for ward 8a in February 2018 noted 0% compliance with fluid management policies and declining compliance with the completion of nutrition records, from 75% in November 2017 to 50% in January 2018. In addition adherence to the MUST protocol had declined from 82% in November 2016 to 60% in January 2018. Senior nurses we spoke with demonstrated variable awareness of this and there was no coherent action plan in place to address the results.

We observed the lunch service in the AMU on one day of our inspection and found this to be a task-based process in the bay we observed. For example six patients had a meal in front of them and were either sleeping or sitting in silence. One member of staff was present completing paperwork and did not offer support three patients who did not seem to want to eat or were not able to. There was no evidence of adapted cutlery or equipment in place and no colour-coded tray system to indicate if a patient needed assistance. The handwashing sink was blocked by four items of equipment and we were not assured patients had been encouraged to wash their hands before eating.

**Pain relief**

An acute and chronic pain management service was available and each ward had a pain link nurse who would bleep the team if a review was needed. This was a Monday to Friday service. Out of hours an on-call core trainee doctor held the pain bleep. However three staff on the AMU did not know about the pain team and would manage pain on the unit themselves.

Out of 27 patients we spoke with, 26 said they felt staff had managed their pain levels well. We observed clinical staff explain pain medicine to patients and relatives in an understandable way, including when discussing palliative medicine with relatives.

Staff demonstrated how they monitored pain as part of the national early warning scores system as well as by using established pain assessment tools during observations and assessments. This included the Abbey scale and the Macmillan pain score for patients being treated in the oncology service.

We spoke with six patients and four carers on ward 8a. In all but one case we were told pain had been managed well. One patient said, “They’re always asking if I’m in pain. It’s nice to know they think of this even though they’re so busy.” Another patient said, “My pain has been steadily increasing and I keep telling them but no-one has done anything.” One patient on ward 6b said, “When I ask for my pain medicine they give it straightaway, I’ve never had to wait.”
Patient outcomes

Relative risk of readmission

Trust level

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

Elective Admissions – Trust Level

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

Non-Elective Admissions – Trust Level

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Pilgrim Hospital

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

Elective Admissions - Pilgrim Hospital

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

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit for April to June 2017 for Pilgrim Hospital indicating it is better than the national average. However the hospital score for Speech and language therapy is a level C with variable scores across each of the last six audits.

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<th>Pilgrim Hospital</th>
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<td>Oct-Dec 15</td>
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<td>Domain 1: Scanning</td>
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<td>Domain 2: Stroke unit</td>
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<td>Domain 3: Thrombolysis</td>
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<td>Domain 4: Specialist assessments</td>
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<td>Domain 5: Occupational therapy</td>
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<td>Domain 9: Standards by discharge</td>
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<td>Domain 10: Discharge processes</td>
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<td>Patient-centred Total Key Indicator Level</td>
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After our inspection the trust provided more up to date SSNAP data relating to August 2017 to November 2017. This indicated a continuation of the hospital’s good performance in this audit. The hospital achieved a grade B for team-centred indicators, a grade A for case ascertainment band, a grade A for audit compliance band and an overall grade B. The trust had implemented a remedial action plan to address areas of underperformance in the audit, such as the development of a specialist stroke nurse coordinator role.

The national standard is that patients who experience a stroke spend at least 90% of their inpatient stay in a specialist stroke unit. Between August 2017 to November 2017 the hospital achieved 83%, which was similar to the 86% national average. Also during this period 63% of patients were admitted directly to the stroke unit, which was better than the national average of 59%.

The hospital monitored care based on the RCP national clinical guidelines for stroke including in relation to the administration of thrombolysis. Between August 2017 and November 2017 the hospital scored an overall grade B in this measure and performed better than the national average in all four criteria. This included 96% of patients receiving thrombolysis (administration of a strong medicine to dissolve a blood clot) compared with the national average of 88%.

The hospital performed better than or similarly to the standard set in NICE quality statement 7 in relation to daily therapy targets. For occupational therapy, 99% of patients achieved the standard compared to 87% nationally. For physiotherapy, 81% of patients achieved the standard compared to 83% nationally. Staffing shortages in the speech and language therapy (SaLT) team meant 45% of patients were seen by the team within 24 hours and those patients seen by the team received support for only 47% of their stay. We saw from looking at patient notes that there were often lengthy waits for a Speech and Language Therapy (SaLT) assessment, including one patient who waited four days before being seen. An incident occurred with this patient that involved an agency
nursing administering unthickened fluids, which resulted in moderate harm. To address this the SaLT team had completed competency training with staff nurses on the stroke unit to enable them to carry out swallowing assessments with patients who met specific risk criteria. This reduced the delay in assessment and meant the SaLT team were able to focus on providing more timely care for patients with complex needs. The average length of stay for patients being treated for a stroke was 6.9 days less than the national average, reflecting targeted work to improve this.

**National Diabetes Inpatient Audit**

**Pilgrim Hospital**

The 2016 NaDIA identified 78 in-patients with diabetes at Pilgrim Hospital, 74.1% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile one.

The following metrics placed Pilgrim Hospital in quartile one and four compared nationally:

The average number of diabetes specialist nursing hours (DISNs and DSNs) spent providing inpatient care per week per diabetes patient. In Pilgrim Hospital, on average 0.89 diabetes specialist nursing hours per week were spent with each patient in 2016, which places this site in Quartile 4.

The chart shows the average number of consultant hours spent providing inpatient care per week per diabetes patient. In Pilgrim Hospital, on average 0.32 consultant hours per week were spent with each patient in 2016, which places this site in Quartile 4.

In Pilgrim Hospital in 2016, 22.2 per cent of patients with diabetes admitted with active foot disease were seen by the multidisciplinary diabetic foot team (MDFT) within 24 hours, which places this site in Quartile 1.

In Pilgrim Hospital in 2016, 46.2 per cent of patients with diabetes experienced one or more medication error, which places this site in Quartile 4. 32.7 per cent of patients with diabetes experienced at least one medication management error, which places this site in Quartile 4. Of the patients on insulin, 28.8 per cent experienced one or more insulin (prescription or medication management) error, which places this site in Quartile 4.

In Pilgrim Hospital in 2016, 78.2 per cent of patients with diabetes reported that all or most of the staff caring for them were aware that they had diabetes, which places this site in Quartile 1, and 50.3 per cent of patients with diabetes reported that all or most of the staff looking after them had enough knowledge of their diabetes to meet their needs while in hospital, which places this site in Quartile 1.

(Source: NHS Digital)

**Myocardial Ischaemia National Audit Project (MINAP)**

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

From April 2015 to March 2016, 30.3% of nSTEMI patients were admitted to a cardiac unit or ward at Pilgrim Hospital and 93.4% were seen by a cardiologist or member of the team compared to an England average of 55.8% and 96.2%. The proportion of nSTEMI patients who were
referred for or had angiography was 31.9% compared to an England average of 83.6%.

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

We spoke with a consultant cardiologist about this who told us the reconfiguration of the cardiology service in the trust would improve performance. This included the appointment of two cardiac specialist nurses in the trust, improved data collection and audit contribution from all three cardiac sites.

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 1.0%, which was does not meet the audit minimum standard of 90%. The 2015 figure was not available.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 16.4%, this was significantly worse than the national level. The 2015 figure was not available.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 58.3%, this is not significantly different from the national level. The 2015 figure was not available.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 48.6%. This is not significantly different from the national level. The 2015 figure was not available. The one year relative survival rate for the trust in 2016 is 31.4%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

Pilgrim Hospital

The crude proportion of patients who had a vision assessment was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 89%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium was 69%. This was worse than the national aspirational standard of 100%.

The crude proportion of patients with an appropriate mobility aid in reach (if applicable) was 100%. This met the national aspirational standard of 100%.

(Source: Royal College of Physicians)

A consultant and a frailty practitioner were leading a frailty pilot at the hospital and saw 176 patients between January 2018 and March 2018. The pilot was based on evidence that patients recover more quickly and have better long-term health outcomes if they are cared for in their home environment. This team reviewed patients who presented to the emergency department (ED) as well as those who were subsequently transferred to the acute medical unit or the ambulatory emergency care unit. As part of the pilot the lead project nurse monitored patient outcomes to present the value of the project to the trust board. We looked at the outcome for each patient seen during this period and found the team were responsive to individual needs. For example they
facilitated fast track discharge for patients with progressing dementia and worked with adult social care services to ensure timely transfers to community services. This team had a significant impact on patient experience and represented an innovative, multidisciplinary and effective approach to providing care for patients with multiple and complex needs. This ensured elderly patients or those with significant needs relating to frailty were supported to access the most appropriate services for them. The frailty pilot team could admit patients to medical specialties, organise transfers of care and work with district nurses and other community teams to plan social packages of care. The team could also ensure patients were cared for in their current location if it would support a safer discharge. For example where patients were dehydrated, had an unconfirmed diagnosis or where they would be unsafe to go home, the team ensured they remained under their care.

A respiratory nurse had introduced an initiative on the AMU that provided a bracelet for patients that detailed their target blood oxygen (SpO2) level. This was designed to help staff identify when to adjust treatment and provide an early warning sign of deterioration. The nurse had implemented this following a review of previous patient outcomes.

**Competent staff**

**Appraisal rates**

From April 2017 to October 2017, 66.2% of staff within medicine at the trust had received an appraisal compared to a trust target of 85%.

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

- Pilgrim Hospital had a 70.8% appraisal completion rate with 216 from 305 having received an appraisal.

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

As part of the trust’s sepsis action plan all staff had undertaken a new practical training programme. This had been delivered by a dedicated team on a one-to-one basis or in small clinical learning groups. This was in addition to the introduction of sepsis e-learning to the mandatory training programme. In addition the sepsis practitioner provided one-to-one supervision and extra training in the use of the new sepsis pathway.
The head of nurse education led the clinical education team, which included an interprofessional practice learning unit (IPLU) team and a team of clinical education nurse, with support from three dedicated administrators and a secretary.

Respiratory nurse specialists monitored the completion of non-invasive ventilation (NIV) competencies against standards monitored by the NIV quality and safety improvement group. An NIV competency policy was in place and was due for review in late 2019. In addition nurses had to successfully complete at least six months post-qualification service prior to beginning NIV training. The divisional risk register identified a lack of capacity to provide NIV as a significant risk to patients and noted an escalation plan to mitigate this risk.

The NIV competency policy for nurses on the respiratory ward meant all qualified nurses were required to take the competency training six months after they had qualified. As of March 2018 seven of the 13 nurses on this ward were out of date for training. However a new ward sister was in post and had arranged for training for all staff whose course had expired. In addition the ward policy stated that each shift must have a nurse trained in NIV and tracheostomy. At the time of inspection some nurses required refresher training for NIV and tracheostomy. To address the risk associated with this the critical care outreach team had introduced teaching sessions to use the outcomes of tracheostomy audits to support staff with learning and development. We spoke with a nurse from this team who told us 14 training sessions had been carried out since April 2017 and they found staff practice afterwards to be significantly better.

The investigations of serious incidents in 2017 indicated a need for improved staff training in trust policies, specialist care pathways and competency assessments. This included a serious incident that resulted in a patient death where the medical director identified the outcome could have been improved had staff followed policy and treatment pathways, including for sepsis screening and management and the management of acute kidney injury. One investigation noted a lack of staff knowledge about renal failure meant the team had been unable to recognise the signs of this. Other serious incident investigations identified some clinical staff lacked understanding of wound management and tissue viability processes and PICC competencies. This meant there had been a negative impact on patient safety and outcomes because staff did not always follow guidelines and policies.

The clinical education team delivered clinical competency workshops for bank staff in venepuncture and cannulation. In addition this team delivered a range of specialist workshops on to HCAs, APs and nurses in 2017/18. The workshops covered 12 subjects or clinical procedures such as sepsis, ligature training and blood cultures.

A practice educator was the lead trainer for dementia, which the trust had introduced as mandatory for all staff. At the time of our inspection 80% of staff had completed this training and the practice educator provided training in line with the University of Stirling dementia framework. A dementia practitioner was able to provide national Dementia Friend training as well as the three-day mechanisms of aging and dementia training. This was not part of the mandatory training and was on demand from individual staff or teams.

Trainee doctors told us they had regular training opportunities through departmental teaching days, weekly grand rounds and monthly regional geriatric training days. They also had protected time for general internal medicine training every month.

The training rota for specialist registrars in the acute cardiac unit had recently been improved by rotating doctors through three of the trust’s cardiac services. This established a more intensive training programme and ensured each unit had sufficient medical cover.
The frailty practitioner had completed extended training to be able to lead a pathway pilot scheme. This included training to carry out medical histories and to complete nurse-led medical assessments. The trust had not approved a training course for the practitioner to become a non-medical prescriber.

The dietician assigned to ward 6a delivered a rolling programme of food services training to improve the quality of food charts. Although this was regularly attended by housekeepers and healthcare assistants, there had been limited attendance from the rest of the ward team.

The trust had placed limits on training and development opportunities available to staff, including in funding travel to free events. This limited the ability of each ward to provide additional training for staff beyond the trust’s mandatory provision.

A clinical educator was dedicated to the endoscopy unit and maintained oversight of core learning. Their ability to source additional training for staff, including ERCP training, had been restricted due to a freeze on spending for learning and development.

Senior staff used a direct observation of procedural skills (DOPS) to assess clinical staff against a competency scale in specific tasks. In the endoscopy unit the clinical educator carried out competency-based DOPs, which were all up to date at the time of our inspection.

All nurses on the stroke unit had completed stroke pathway training.

The clinical education team and divisional leadership team had carried out a programme of work on wards 6a and 6b to improve care for patients living with dementia through improved training.

We spoke with a student nurse who said their four week induction period had been intensive and appropriate to their new role. They said the mix of classroom and practical supernumerary time had helped prepare them for the pace of their unit.

A critical care nurse educator had delivered training to new staff nurses and assistant practitioners in the AMU in the management of diabetic ketoacidosis. This followed an incident in which a patient was unnecessarily transferred. In addition the ward sister carried out a morning walk-around to identify patients with this condition and the diabetic nurse specialist also carried out a daily walk-around to review patients.

**Multidisciplinary working**

A clinical lead for therapies and rehabilitation medicine led a team of physiotherapists, occupational therapists, dieticians and rehabilitation medicine consultants. A site lead for each therapy specialty was in post and dedicated to this hospital. A site lead physiotherapist and site lead occupational therapist led individual teams dedicated to acute care, medical care and stroke. In addition a physiotherapist and assistant provided community neuro-rehabilitation outreach services.

Clinical teams told us the turnaround times for investigations including blood tests and radiology were consistently good and usually took no more than 3.5 hours.

A psychiatric liaison team was available between 8am and 10pm Monday to Friday and provided a liaison and crisis service within four hours of referral. Staff were unable to tell us if there were out of hours arrangements for a patient experiencing a mental health crisis.

The frailty pilot scheme involved the multidisciplinary team and there was consistent support from the radiology service. This team were able to expedite diagnostics to support the discharge target of 24 – 36 hours. The therapies team also provided rapid assessment to support a timely, comprehensive discharge plan. The trust had limited the pilot to 10 weeks, which had restricted the ability of the two members of staff leading to network with appropriate community partners.
Although the frailty team had to go to the ED themselves to identify patients proactively, there was a productive working relationship with the AMU team who would refer patients who may benefit from the service.

All nurses and HCAs received training in diabetic care and a diabetic nurse specialist was available to support staff and review patients.

We looked at the records of nine medical patients who were being cared for as outliers on surgical wards. In each case we found evidence of consistent review by the MDT, including occupational therapy, physiotherapy, SaLT and dietetics.

We attended a board round on ward 6a and saw it was attended by a wide range of multidisciplinary professionals who demonstrated detailed understanding of the needs of and plans for each patient. This included staff from community teams and a social worker to help coordinate discharge plans for patients with complex social needs.

**Seven-day services**

Care of the elderly (CoE) was not a seven day consultant led service. The service was covered Monday to Friday 9am to 5pm CoE cover. 9am to 9pm weekend cover was provided by medical consultant on call, CoE consultants were on this rota. Overnight a medical consultant covered with CoE consultants within that rota.

Consultants provided a seven day service in the acute cardiac unit with weekend cover provided through an on-call system.

The endoscopy unit provided services seven days a week, from 8am to 7pm on Mondays, Wednesdays and Fridays and from 8am to 8pm on Tuesdays and Thursdays. At the weekend the service operated from 8am to 1pm.

Physiotherapy and occupational therapy services were available seven days a week from 8am to 4pm.

Pharmacy, x-ray and radiology services were available seven days a week.

**Health promotion**

Health promotion information from national dementia organisations was readily available on care of the elderly wards. Staff on ward 6b had prepared an information board for the relatives and friends of patients living with dementia. This was detailed but accessible and staff had avoided the use of jargon or complex medical language. Instead they included useful information such as ‘20 things not to say or to do to a person with dementia’. This was designed to reduce the mystery of the condition and to help relatives and friends understand how to improve their communication.

Each ward team had collected a range of health promotion materials relating to the most common health concerns patients presented with or talked about. These were related to the specialty of the unit, such as the stroke ward, and included signposting to local and national specialist organisations.

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

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

The trust reported that from April 2017 to October 2017 Mental Capacity Act (MCA) training had been completed by 85% of staff within medicine.
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses</td>
<td>541</td>
<td>619</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>89</td>
<td>109</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust have confirmed that the deprivation of Liberty training is included in the mental capacity act training module within the mandatory training data provided by the trust.

(Source: Routine Provider Information Request (RPIR) Training)

We found significant improvements in the use of the chemical restraint policy. Clinical teams had reviewed and updated the policy and introduced new guidance on its use. Staff used a register to document when they used chemical sedation and senior clinical teams reviewed these as part of incident reporting processes to ensure they were appropriate and proportionate. We looked at the registers in each clinical area and found a consistent standard of documentation and use of the policy in clinically-justified circumstances.

We saw during our observation of handovers and ward rounds that staff routinely included assessments of mental capacity in all areas of care and treatment planning.

We saw evidence of appropriate mental capacity assessments and documentation of best interest decisions to support patients and staff in specific circumstances. For example staff used a best interest checklist to assess the impact of delirium and the likelihood the patient would regain their usual level of capacity. However, we were not assured of the consistency of mental capacity assessments because of the number of documents missing from patient records. For example in five cases consultants or senior ward nurses told us individuals patients had a capacity assessment in place but could not find evidence of this in any instance. This meant we were not assured all staff had access to the latest mental capacity information for each patient.

During a ward round on the AMU we saw clinicians used a mini mental state assessment as part of the CQUIN confusion assessment. They completed this sensitively and with no distress to the patient.

We saw evidence staff proactively made referrals for an independent mental capacity advocate (IMCA) when patients needed additional support to make decisions or to understand their circumstances.

We found appropriate consent processes were in place in the endoscopy unit, including evidence staff checked the consent forms patients were required to read and sign at home in advance of their procedure.

Staff obtained verbal consent prior to undertaking interventions on patients.

Senior staff on the AMU had prepared a support file to encourage appropriate use of the MCA and DoLS. This included examples of good practice in both as well as flowcharts for their use and a DoLS scoping tool. We spoke with two staff nurses about this who demonstrated a high level of knowledge and understanding of mental capacity assessments and the use of DoLS. In addition the frailty nurse practitioner had delivered focused education sessions on the MCA and DoLS.
Is the service caring?

Compassionate care

Friends and Family test performance

From December 2016 to November 2017 the Friends and Family Test response rate for medicine at the trust was 28% which was better than the England average of 25%.

- Pilgrim Hospital Boston: 26% from a total of 1,289 responses

The friends and family test percentage recommended by ward for medicine at the trust is shown in the table below:

Pilgrim Hospital Boston:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Responses</th>
<th>Res. Rate</th>
<th>Dec 16</th>
<th>Jan 17</th>
<th>Feb 17</th>
<th>Mar 17</th>
<th>Apr 17</th>
<th>May 17</th>
<th>Jun 17</th>
<th>Jul 17</th>
<th>Aug 17</th>
<th>Sep 17</th>
<th>Oct 17</th>
<th>Nov 17</th>
<th>Ann Perf</th>
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</thead>
<tbody>
<tr>
<td>Stroke Unit</td>
<td>149</td>
<td>29%</td>
<td>91%</td>
<td>86%</td>
<td>94%</td>
<td>100%</td>
<td>20%</td>
<td>100%</td>
<td>80%</td>
<td>88%</td>
<td>88%</td>
<td>100%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>6A</td>
<td>26 9</td>
<td>56%</td>
<td>100%</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>95%</td>
<td>97%</td>
<td></td>
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<tr>
<td>6B</td>
<td>17 1</td>
<td>27%</td>
<td>91%</td>
<td>86%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
<td>100%</td>
<td>96%</td>
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<tr>
<td>7A</td>
<td>18 4</td>
<td>23%</td>
<td>90%</td>
<td>89%</td>
<td>100%</td>
<td>82%</td>
<td>92%</td>
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<td>93%</td>
<td>100%</td>
<td>91%</td>
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<tr>
<td>7B</td>
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<td>23%</td>
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<td>88%</td>
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<td>100%</td>
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<td>81%</td>
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<td>8A</td>
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<td>73%</td>
<td>78%</td>
<td>84%</td>
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<td>80%</td>
<td>69%</td>
<td>82%</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>ACU</td>
<td>13 4</td>
<td>24%</td>
<td>88%</td>
<td>80%</td>
<td>88%</td>
<td>100%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
<td>88%</td>
<td>92%</td>
<td>91%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

During all of our observations we saw staff used a kind and caring approach with patients. We saw staff on ward 7b used an understanding and calm response when a patient behaved disruptively and aggressively due to mental health issues. On the AMU we observed a consultant speak gently with a very sick patient and bend down so they were eye level with them. Also on the AMU we saw a senior nurse and consultant speak with a terminally ill patient in a very caring, understanding without condescension. Both individuals spoke in a similar manner with the patient’s relatives and used an open and honest approach without being unnecessarily blunt and using genuine empathy.

In the 2017 national patient-led assessment of the care environment (PLACE), inpatient medical wards scored 81% in the assessment for privacy, dignity and wellbeing. This was a slight deterioration from the 2016 PLACE score of 85%.

The trust operated a carer’s scheme that enabled carers to access more affordable parking, open visiting hours and subsidised hospital food. This was designed to reduce the pressure on carers during a time of stress. Carers were issued with a bright orange lanyard, which they could choose to wear to avoid being challenged by staff if they were in clinical areas outside of visiting times. Wards advertised the orange lanyards as a mark of respect to encourage their use and notices described carers as “incredibly important” in the patient journey. Carer guidance also encouraged carers to discuss with staff the level of involvement they wished to have.
We observed a consultant ward round on ward 7b and saw the team demonstrated awareness of patient confidentiality and held discussions away from patients and out of earshot.

Some wards displayed dignity in care pledges in public areas to establish the standards of dignified care patients and visitors could expect. On ward 6b this included a statement highlighting the team’s commitment to the care of people living with dementia. The acute cardiac unit (ACU) had used guidance from the National Dignity Council to establish local priority indicators that staff provided care with dignity. For example each member of staff looked for evidence that colleagues treated patients with respect.

We spoke with 27 patients and 11 relatives or carers. One patient on ward 7b said staff had been very kind and reassuring after they were admitted following emergency care and said, “It seems weekend care is very good here. Everyone has been so friendly to me.” One patient on the acute medical unit said, “I’ve had fantastic care here, the best you can get. Everyone gives you as much time with them as you need.” Five patients and four carers on ward 8a spoke highly of the care they had received. One patient said, “They’re [staff] absolutely marvellous here. I’ve been looked after better than at home.” A carer said, “We’ve very much been spoken to in a respectful way here.” One patient said they felt staff were disrespectful of them because they had reduced vision. They told us, “They [staff] make sarcastic comments about how often I come back here but I don’t think they realise how condescending they are.” This patient’s clothes had been misplaced on the ward and the alternatives provided by the team did not maintain their dignity. For example we saw their hospital gown was too small, their vest was stained and their underwear was visible as they moved around the ward. We spoke with a member of staff about this who told us the patient had refused to allow them to change their clothes.

On the stroke ward we saw staff had worked above and beyond their clinical duties to arrange for a long-term patient to carry out their wedding ceremony on the unit.

One patient on ward 6b said, “Every nurse except one is respectful and friendly. I rang my call bell in the middle of the night last night because I had stomach pain and they came really quickly. One nurse is very impatient and keeps telling me to hurry up when I’m moving but she’s an exception.” Another patient on this ward said, “I waited so long for someone to answer my call bell last night that I wet myself.” Another patient on this ward said, “They keep telling you ‘someone will be with you in a minute, just wait’ but that never happens. I can’t use the toilet easily by myself but staff seem to think I can and so I wet myself waiting for them the last time I asked for help.” One patient on 7b said, “I know they’re so busy but I have had to keep urine bottles next to my bed because sometimes I can’t wait that long for them to come and help. I often have to press the buzzer four times before someone comes and it can take a long time.” We spoke with staff who were not aware of these specific instances but said they often too busy to respond to call bells in a timely way.

One patient on the ACU said, “Nothing is every too much trouble.” Another patient on this unit said, “Staff are fantastic and always here for you. There’s a student nurse here as well who is fantastic.”

On our last inspection we identified concern in relation to the care of patients on ward 6a, this included patients not being treated with dignity and respect, a lack of compassion and patients not having access to call bells. During this visit (February 2018) we saw significant improvements in patient care on ward 6a. We saw staff interacting with patients in a compassionate manner, patients were treated with dignity and respect and all patients had access to call buzzers. Staff on this ward demonstrated their commitment to delivering good care and treatment. The ward environment was conducive to a positive experience for patients for example it was calm. Staff
had received enhanced training. We saw staff interacting with patients in a positive manner. We saw a patient who became distressed was treated with upmost respect and staff were able to de-escalate the patients anxiety.

**Emotional support**

The parent of a young patient in the AMU said the team had provided and “excellent” level of emotional support to both of them following a transfer from another hospital that had been upsetting. They said, “All it took was a quiet word with a nurse and I was allowed to stay with [the patient] overnight. They’ve offered me drinks and snacks and seem very comfortable just chatting to help us focus.” One patient on the AMU said, “I was confused when I came in yesterday but I do remember how lovely staff were and how gentle they were with me.”

Ward staff and senior staff spoke highly of the chaplaincy service. One senior nurse said, “They’re fabulous here. Good at facilitating and they’re very intuitive.”

One patient on ward 7a said, “I was here last year and it was not very nice. This time it’s much improved. Everyone is much more caring and the whole atmosphere is better.”

During all of our observations we saw staff spoke gently to patients and recognised when medical or clinical information might cause distress.

We saw a number of nurse specialists in clinical areas providing emotional support to patients, such as the diabetic nurse specialists.

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

The trust was developing a new bereavement survey that would more closely establish the needs of relatives and enable a more comprehensive end of life care service to be established. This was part of a range of improvements to establish bereavement services in line with national programmes and pathways.

Results from the 2017 audit of compliance with national standards for venous thromboembolism (VTE) screening found that only 33% of patients were given information about the condition and risk on discharge. Although staff stated all patients were given this information the percentage related to patients for whom there was documented evidence.

During our observations of a consultant ward round on ward 7b we saw members of the medical team involved patients in discussions about their care, including planned treatment and multidisciplinary input. Doctors spoke with patients in straightforward terms and avoided using jargon. They also asked each patient if they understood what had been said and rephrased it if they had not understood. Patients we spoke with felt positively about the way clinical staff had involved them. One patient on ward 7b said they appreciated the honesty of doctors and that they were honest when they did not know the answer to a question.

From our observations in the AMU we found staff routinely included patients and their relatives in discussions about discharge plans and estimated dates. Patients we spoke with confirmed this and five patients we spoke with said they appreciated the openness and honesty of staff. Patients and carers we spoke with in the AMU said they appreciated the efforts of staff to look after their holistic needs above and beyond their clinical needs. For example one carer said, “[My relative] was admitted in the middle of the night. The nurse on the AMU asked if we’d eaten and even
though [relative] just wanted to sleep they made me something to eat. That meant a lot to me at 3am when I was tired and hungry.”

On ward 8a we observed a healthcare assistant (HCA) gently support a patient to improve their sitting position to reduce the risk of falls. Although the patient was reluctant to do this the HCA explained in straightforward terms how their sitting position put them at risk and what they could do to reduce this. Once the patient understood the risk they moved their position, potentially avoiding a fall.

Staff in the endoscopy unit adhered to a policy that meant no bad news would be discussed with patients in the treatment room. Instead they waited until the effects of sedation had worn off and used a private meeting area. This ensured patients were able to understand the information and treatment plan.

Although patients and carers in the stroke ward spoke highly of the kindness and compassion they had experienced, some individuals told us they did not feel included in the treatment plan. For example one carer said, “[My relative] was admitted five days ago but we haven’t had a proper sit down with the doctor yet to find out what’s happening. Everyone is so nice but they’re vague about what’s happening and even though I keep asking to speak to a doctor they all seem too busy.” Another patient said, “No, I don’t feel listened to. Everyone is lovely but they don’t listen because they’re too busy rushing. Staff are nice but they’re not talking to each other and I wish I knew what their plan was for me.” One patient said, “I am a frequent patient here but each time I come in staff raise up my hopes. They don’t seem to understand that what they tell me will happen [in the community] when I leave doesn’t. I wish they’d talk to each other more and figure out why I keep coming back in. It feels dismissive when they tell me I’ll be okay after I leave.”

We saw during our observations on ward 6b that staff patiently supported patients to take their medicine. For example we saw one patient was nervous about taking their medicine and also nervous about making the nurse wait. The nurse reassured them without rushing and told the patient they could take as long as they needed. This demonstrably calmed the patient and resulted in a successful administration of medicine.

One patient on ward 7a said, “The whole team is brilliant. The treatment they planned isn’t working. The doctor told me why and what they were going to try instead and we had a chat about it. The consultants always come and say hello and they involve my [relative] in everything too. The only improvement would be if they looked at the facilities on the ward – they’ve told me to elevate my feet when I sit down but I can’t do this with the chairs they’ve got.”
Is the service responsive?

Service delivery to meet the needs of local people

Average length of stay

Trust Level

From October 2016 to September 2017 the average length of stay for medical elective patients at the trust was 3.2 days, which is lower than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 6.4 days, which is lower than the England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical oncology (previously radiotherapy) is lower than the England average. It was also lower for cardiology and clinical haematology.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in cardiology and for geriatric medicine were both higher than the England average.

Elective Average Length of Stay – Trust Level

Non-Elective Average Length of Stay – Trust Level

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

Pilgrim Hospital

From October 2016 to September 2017 the average length of stay for medical elective patients at Pilgrim Hospital was 2.3 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 6.1 days, which is lower than England average of 6.6 days.
Staff used a room to provide more targeted care for patients living with dementia who were experiencing distress or disorientation. This room included a ‘feature wall’ that was designed in colours that are known to help patients to orientate themselves.

Each ward had an orientation board at the entrance that enabled visits to orientate themselves and identify different staff roles through their uniform colour.

Senior clinicians recognised the significant demand on the hospital from a proportionality high number of elderly people in the local population. To ensure clinical services continued to be able to address their needs, the hospital was actively recruiting more palliative care staff.

The stroke unit had beds for thrombolysis where patients received one-to-one nursing care and staff were trained to carry out care in accordance with a stroke checklist and pathway.

A frailty practitioner and frailty consultant had re-established a frailty pilot following a previous programme after which the trust did not accept the business case for a permanent service. The pilot represented an innovative approach to reducing unnecessary admissions and providing a highly specialised, multidisciplinary service for frail patients. Although the pilot was generating audit-based evidence of improved outcomes for patients there was a lack of governance oversight or support from the trust. For example if the nurse practitioner could not attend work due to illness the service stalled as there was no process in place to secure cover. In addition there was no designated area to accommodate patients for a short-term period whilst the team assessed them. This would typically be for up to 36 hours but the lack of dedicated accommodation meant patients in the service could be transferred and moved without the frailty team being notified. For example the frailty team completed advanced care planning and immediate risk assessments for hydration

(Source: Hospital Episode Statistics)
followed by a 24-hour period of monitoring. However, the team often found the patient had been transferred from the AMU to an inpatient ward, which meant they could no longer use the frailty pathway. We saw this in practice for one patient who had been admitted as a medical outlier to ward 3b with a frailty assessment template that had not been completed by ward staff.

Facilities and premises were appropriate for the services being delivered and had been adapted to ensure access for patients who used wheelchairs.

**Meeting people’s individual needs**

Nursing staff had the opportunity to take on ‘link’ roles, which enabled them to specialise in specific areas of care and treatment. This involved undertaking more advanced training in the subject with clinical nurse specialists and delivering learning and training to colleagues on their ward. Link staff, who could be nurses, healthcare assistants (HCAs) or assistant practitioners (APs), also prepared information displays on their wards to provide colleagues with access to facts about conditions and to guidance on care and treatment. Link staff on ward 6a each maintained an up to date folder with information on their topic and all staff on the ward were required to read updates and document when they had done so.

A dedicated team of volunteers provided individual support for patients on wards. This team were competency-assessed using a structured checklist and had supervision from a placement manager. This ensured they could deliver support to patients within established boundaries and with a good understanding of health and safety policies and principles. The volunteer assigned to wards 6a and 6b had provided individualised support to patients. For example they asked patients where they were from and then researched the local and saved historic pictures they could show using the audio-visual dementia resource tool. The ward teams had held a raffle to raise money for earphones so that volunteers and staff could play music to people they recognised or that brought them comfort.

In the 2017 national patient-led assessment of the care environment (PLACE), inpatient medical wards scored 66% for the dementia-friendly environment and 81% for adaptations for patients with a disability. Both scores were similar to the overall hospital averages in these measures and both reflected improvements in both measures from the 2016 PLACE results, from 65% for dementia criteria and 73% for disability criteria.

Where patients presented with violence or increasing aggression staff had been trained to use a chemical sedation policy. We reviewed the assessments staff completed to carry this out safely and saw this included a rapid mental capacity assessment and a review of past medical history. Staff also noted if the patient had a history of depression and whether their behaviour would contribute to a change in discharge planning.

Staff used an ‘activities of daily living’ care plan to help support patients in distress, living with dementia or those who were confused. This helped staff to understand their usual daily routines and try to adhere to these to give patients a sense of continuity.

There was limited provision for patients who presented with needs relating to drug and alcohol addiction. Staff told us they would refer to the mental health liaison team or to the specialist mental health ward if they needed support in such cases.

Two learning disability champions were available in the hospital; one qualified nurse and one healthcare assistant. This team liaised with colleagues across the hospital to provide targeted, on-demand support for patients.
A dedicated dementia practitioner had been assigned to a commissioning for quality and innovation framework (CQUIN) for a confusion assessment for all patients over the age of 75 years within 72 hours. The practitioner liaised with community teams and referred to other organisations to help coordinate post-discharge care plans. Where the practitioner identified delirium in addition or instead of dementia they liaised with the appropriate clinical specialist and worked with ward teams to initiate enhanced care. The practitioner covered 13 wards and the trust had appointed an associate practitioner to increase capacity on wards 6a and 6b.

Care of the elderly wards provided ‘twiddle muffs’ for patients living with dementia. Twiddle muffs are fabric sensory bands that enable patients to occupy their fingers and therefore reduce tension and stress through distraction. In addition wards had a digital television system that enabled staff to tailor specific reminiscence material to each patient, such as to a specific period in their life. This was a mobile system that could be used in individual bed spaces. We observed this system in use and saw staff had configured it to provide patients with music, films, political speeches and poetry from their generation.

Staff in care of the elderly wards used an enhanced care ‘prescription’ to support patients with additional needs relating to dementia. This included a daily self-care diary and a record of personal and social history information staff could use to provide individualised care.

There were very limited resources for the non-clinical care of patients who spent extended periods of time in the hospital. Staff had provided equipment such as games out of their own pocket. Although a day room on the AMU had been converted to a clinical side room, this provided staff with a more appropriate space to provide care for palliative patients. However the room conversion meant the unit had no dedicated space for social interaction for patients and no room for mental health assessments or for holding difficult conversations with relatives.

We observed a very high standard of care on the AMU for a patient approaching the end of their life. The consultant and senior nurse discussed care and pain management options with relatives and ensured they were looked after. For example they told the patient’s family not to worry about adhering to visiting times and told them they could have as many people around the patient’s bed as they wanted. They also ensured relatives understood the involvement of the palliative care team, how to contact them and options to consider for a referral to a local hospice.

We observed effective use of a language interpreter to assist communication with a patient. For example staff had arranged this to support a discussion with a patient experiencing memory loss and who did not speak English. An interpreter and the clinical and multidisciplinary team demonstrably worked well together to ensure this patient understood important information about their care.

Staff on ward 8a had worked with the dementia lead practitioner to improve signage for toilets and bathrooms as part of a drive to make the environment more accessible for patients.

Nurses, APs and HCAs used rounding observation charts to monitor each patient in addition to their clinical treatment and ensure their individual needs were met. We looked at a sample of eight rounding charts on wards 8a and 9a and found them to be consistently completed at the intervals identified by a clinician. The ward sister on AMU had introduced a new admission checklist with hourly rounding for HCAs to complete and said this had improved consistency of completion.

Staff were able to meet the care needs of patients receiving bariatric care through the provision of modified wheelchairs, beds and seats.
The rheumatology service had initiated a follow-up service to support patient progress after discharge. The divisional leadership team told us this had been successful and they were exploring opportunities to extend the programme to other specialties.

Wards were fitted with coloured handrails to help patients mobilise and move around them freely. However on ward 9a the corridors were used for storage, which meant patients could not easily use them.

Ward 9a was equipped with a training kitchen and a physiotherapy gym to provide patients with rehabilitation prior to their discharge.

Four palliative care link nurses were in post and support staff with discharge planning, including in ensuring patients were supported to die in a location of their choice. In addition one palliative care nurse delivered training to ward staff to enable them to be more confident in delivering care to palliative patients.

A dementia support practitioner worked with an Alzheimer’s team to deliver focused training and support the delivery of care to patients. In addition clinical educators were able to deliver the national ‘making a difference’ in dementia course, which provided staff with a more detailed understanding of the condition and how it presented in patients.

**Access and flow**

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

Trust’s referral to treatment time (RTT) for admitted pathways for medicine has been similar to the England average for the whole time period between November 2016 and October 2017.

In October 2017 (and November 2017) the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.

From November 2016 to September 2017 the trust showed an average of 75% versus the England average of 90%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>71.7%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>63.2%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>88.9%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>74.7%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Where a patient presented in the emergency department and needed to be admitted to the stroke unit, a nurse and doctor from the unit attended to review the patient and carry out a transfer.

The clinical lead for care of the elderly services had established new working relationships with community hospitals to improve access and flow for older patients. This included providing training for staff in the use of the electronic patient records system used by community hospitals and GPs to provide more coordinated care and transfers.

During periods of exceptional demand, a theatres recovery area was used as an escalation area to accommodate medical patients. This areas forms part of the agreed escalation process. This was staffed by one medical nurse and one surgical nurse with support from a foundation level doctor and the directorate leadership team had a requirement that at least one substantive trust nurse be present at all times.

Patient moves per admission

The trust said within their routine provider information request that they “currently do not collate reason for patient moves so unable to supply this data”.

The trust were able to report how many times a patient had a ward move between 22:00 and 08:00am by ward between November 2016 and October 2017.

- Pilgrim Hospital Boston had 4,679 (389 a month)

(Source: Routine Provider Information Request (RPIR) – P52 Bed moves at night tab)

From looking at records we saw staff began discharge planning at the time of admission and reviewed estimated discharged dates daily during multidisciplinary board rounds.

A discharge lounge was open daily and staff provided care for patients awaiting transport home or waiting for to take away medicines before they could leave. We saw the discharge lounge was used appropriately and staff ensured only patients who met the safe care criteria were transferred there.

A site team of bed coordinators managed access and flow in the hospital using three daily coordination meetings. The meetings involved staff from each clinical and non-clinical service helped to support timely discharge and the admission of patients to appropriate inpatient areas.

Learning from complaints and concerns

Summary of complaints
From October 2016 to September 2017 there were 188 complaints about medical care from a total of 750. The trust took an average of 75 days to investigate and close; although this was not in line with their complaints policy, which states complaints should be completed within 35 days (80% of them) and complex complaints should be responded to within 50 days, we saw that there had been improvement in response times since our last inspection. Quality of complaint responses had also improved.

The top three categories reported for medicine were communication with patient (21) followed by communication with relative/carer (18) and 15 associated to delay or failure to diagnose (including e.g. missed fracture). We saw

There are 41 complaints within medicine that were put against individual subjects, of these at least nine were associated to communication between staff and patients and their families, as well as 16 related to delay and failure around observations, record keeping and waiting times.

General medicine had the most complaints reported against a specialty with 39, followed by oncology with 30 and 25 against cardiology. 32 complaints were reopened of which none have been reclosed.

- Pilgrim Hospital Boston: There were 72 complaints, the top two categories reported against each receiving nine complaints were communication with relatives/carers as well as delay or failure to diagnose (inc e.g. missed fracture).

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

The senior nurse on each ward demonstrated an understanding of complaints received and maintained a track record to identify themes. They used the outcomes of complaints to improve training for staff and experience for patients. For example one complaint on ward 6b related to communication between staff and the relatives of a patient who received palliative care. As a result the senior team planned to improve communication guidance for staff when discussing sensitive subjects such as a patient’s wishes about where they wished to die.

The ward sister on the AMU had introduced a new admissions checklist and a property checklist, which had resulted in an average of 10 fewer complaints per month from December 2017 to February 2018.

Is the service well-led?

Leadership

Specialist and acute medical services were organised into one clinical directorate within the integrated medicine business unit. The clinical directorate had a triumvirate leadership team with a clinical director, general manager and a head of nursing. Directorate teams included a matron, business manager, eight heads of service and six other managers and support officers.

The meeting process for consultants had recently been streamlined, which meant heads of service met and then communicated the outcomes to their consultant teams. This reduced the need for consultants to miss clinical time for meetings.

Ward 7b had operated without a substantive ward sister for one year and staff told us this had resulted in a high rate of staff turnover and a deterioration of standards. Following our inspection,
the trust told us that there had been a ward sister from ACU manging ward 7b during this time. The trust told us following our inspection a substantive ward sister had commenced in post following our inspection. Although a matron was responsible for this ward, a series of four seconded matrons had taken the post in a period of 14 months, which reduced consistency for staff. This had also impacted senior nurses on the unit, including the clinical educator who had not been able to access protected administration and planning time for over one year. Most ward sisters told us they were not able to use any time for administration, which meant areas such as meeting minutes, preparing business cases or carrying out one-to-ones with staff were not possible.

The matron for haematology, oncology and chemotherapy worked on a trust-wide basis and matrons for other specialties were based at this site permanently.

Most ward-based staff said they felt the head of nursing and business managers were visible and easy to reach if needed.

There had been improvement in the local ward leadership across many wards since our last inspection. Ward sisters / charge nurses were included in the trust leadership programme which had improved their skills in leadership.

Matrons were very operational which meant they often did not have time for quality improvement.

**Vision and strategy**

The trust had an overarching people strategy that, alongside the Lincolnshire sustainability and transformation plan, aimed to facilitate the development and improvement of clinical services. The trust incorporated staffing measures such as sickness and vacancy rates and incorporated a need for significantly improved staff morale as a key measure of success. Four core measures of the plan directly involved staff in wards and departments with substantive focus on identifying and developing talent. During previous inspections we found staff had very limited opportunities to progress and there was a pervasive feeling of apathy amongst many clinical teams. The trust acknowledged this and had structured the new strategy to engage staff and encourage a culture of enthusiasm that contributed to a sustainable service. The senior trust team had established a staff charter to support the people strategy with behavioural standards and a support structure to help staff develop their skills and role.

Each ward team had developed a vision and philosophy of care. This was displayed in each ward and outlined how they strived to provide care and the key areas of importance for them. For example the philosophy of care on ward 7b placed compassion, respect, a positive attitude and equality as central to care delivery.

**Culture**

Ward staff spoke positively of communication within their teams and with their senior colleagues. Staff on some wards had established secure, restricted-access social media communication groups to enable them to stay up to date with changes and new policies. This meant staff could stay up to date even if they could not attend staff meetings.

Staff on the acute cardiac unit (ACU) identified the confidence to raise concerns and to challenge decisions as a key goal for team improvement.
Ward staff told us the head of nursing was accessible and approachable and said they regularly visited each ward. In addition they felt that local support was good but they did not feel part of the trust. One senior nurse said, “The trust focuses on the Lincoln site even when they’re looking at community services. It feels less and less that we’re providing a viable service or that the trust notices what we’re doing.” However other staff we spoke with were happy with their relationship and involvement with the trust. One nurse said, “We work for the trust not just the wards and we don’t want to see anyone stuck in rut – so we use all of the resources we have in the trust to help them out and support them.”

The head of nursing had established ‘hold and challenge’ meetings to enable staff from all roles to challenge plans, practices and policies. This was part of the trust’s work to ensure teams worked openly and staff felt empowered to raise issues and concerns.

The risk team reviewed each incident to identify if staff had communicated with the patient and/or their relatives in line with the duty of candour requirements. Where this was not the case the risk team escalated it to the deputy chief executive officer to resolve. The policy for the duty of candour was for the clinician responsible for the patient to write to them with an explanation of the situation. The business manager was the named lead for the duty of candour and worked with the risk team to ensure compliance.

The directorate leadership team spoke positively of improvements at a senior level and described a greatly improved relationship and communication with their surgical counterparts. They said this resulted in faster liaison when needed.

We were not assured that a positive safety and risk management culture was in place when patients were transferred from the emergency department (ED) to the AMU. For example staff on the AMU said they had submitted incident reports regarding poor care on the ED but received no response from the trust or engagement from the ED. In one incident a patient was transferred from the ED to the AMU with multiple rings of dried urine on their bed sheets. In another incident a patient was transferred from the ED and AMU staff found six pressure areas that the ED team had not documented. Although staff had submitted an incident report in both cases they said they had not received any feedback.

Ward sisters and charge nurses from medical wards met weekly but there was no equivalent structure in place for senior nurses in the AMU and emergency care, which resulted in a lack of effective communication. One senior nurse said, “There’s no forum for us to discuss our joint struggles with our colleagues on the wards. We’re quite isolated here and there’s little communication with the rest of the hospital.”

The AMU had operated without a ward sister or charge nurse for several months leading up to August 2017 and the member of staff appointed to this role had implemented a series of changes to improve performance and the working environment. This included abolishing a permanent night shift rota following a significant number of complaints and incidents overnight. Instead staff rotated through different shifts, which had helped reduce the number of adverse reports overnight. The new ward sister said the AMU team prided themselves on their good working relationships and new opportunities to socialise had been arranged, which had improved morale.

**Governance**

The senior directorate team described the clinical governance system as starting at ward level. This meant governance issues and assurance were connected directly to directorate-level governance structures, which were overseen by heads of service. Clinical cabinets for nursing and
Evidence appendix United Lincolnshire Hospitals NHS Trust

governance maintained oversight of governance outcomes and the triumvirate leadership teams reported into patient safety committees. Each cabinet team attended a monthly operations meeting and clinicians and matrons attended monthly meetings for job planning. Each medical specialty held their own governance meetings and the clinical director joined them as needed to provide oversight of the assurance process.

Directorate teams and senior clinicians used a series of clinical governance meetings to review patient outcomes, morbidity and mortality. This included a review of patient deaths, serious incidents and complaints as tools to assess performance. We looked at a sample of meeting minutes from three governance meetings. In each case the meeting was well attended by an appropriate cross-section of staff and there was a tracking system in place to resolve incidents, complaints and other events. Clinicians presented findings from investigations into clinical outcomes and shared these for distribution through patient quality and safety processes.

The duty of candour formed part of the incident investigation process and staff were required to document how they had informed the patient and/or family member involved. However in the 25 incident investigations we looked at, staff had not completed any of the eight stages of the duty of candour requirement and in 13 had only partially completed this. For example the investigation into a grade four hospital-acquired pressure ulcer found the ward nursing and medical team had not notified the patient or their next of kin about the incident. Similarly a ward team that failed to react to a deteriorating patient had not implemented any of the trust’s eight requirements on the duty of candour and on the same ward the team had not discussed the severe harm caused to a patient in renal failure because trust policy had not been followed. The trust recognised it had further work to do to embed duty of candour requirement’s and we saw work going on at trust level to improve this.

There was a demonstrable and significant lack of senior governance in the oversight of serious incidents and how these applied to clinical risks. As of February 2018, medical care services had 36 overdue serious incident reports. This was reflected in the divisional risk register, which noted intervention by the risk team, the clinical director and specialty governance teams had been ineffective and that time identified for staff to complete investigations had not been used for this. The risk register indicated medical care had more serious incidents than any other hospital department and delays to investigations meant further risks resulted from a lack of learning outcomes. There was no evidence the senior team had identified solutions to this risk.

Consultants included morbidity and mortality reviews in monthly clinical governance meetings and used the outcomes to implement improved working practices and provide learning opportunities for clinical supervisees.

Ongoing short staffing on ward 8a had contributed to declining performance and there was limited evidence clinical governance processes had addressed this. For example in the quality and safety red, amber, green risk rating, ward 8a had been rated red for the completion of falls risk assessments within 24 hours since July 2017. As at February 2018 the ward had scored 54% in this audit and audit results for food and fluid monitoring demonstrated a declining trend. Nine training dates for diabetic fluid balance days had been scheduled for February 2018.

The haematology-oncology matron led monthly governance meetings for the service with a minimum attendance standard of three nurses. The matron kept a laminated overview of governance standards so that they could easily display and update this for each senior nurse.

Governance of the hospital at night and critical care teams had been merged. We spoke with a critical care outreach nurse about this, in the context of their care for medical patients who were deteriorating. They told us it was an effective working arrangement because it meant they had
access to the expertise of intensive care doctors as well as the hospital at night and site medical team. The clinical lead for the outreach team was based in the intensive care unit and the team attended governance meetings from both acute medicine and from critical care.

A new head of nursing was in post and had introduced a programme of improvements for tracheostomy care. This included a new standard operating procedure and the implementation of a tracheostomy working group that monitored weekly performance and safety outcomes.

Management of risk, issues and performance

Each ward had a safety and quality dashboard that was used to monitor risk, performance and quality. This included an overview of contributing factors such as incidents and accidents as well as data from the NHS Safety Thermometer. The dashboard provided an overall score and enabled ward teams to quickly identify where they needed to focus improvements and where they were achieving a high standard.

From our review of serious incident investigations a key and pervasive theme was a lack of staff competency oversight and monitoring. The hospital reported 25 serious incidents in 2017 on medical wards and all investigations identified areas for improved staff training or competency assessments. While this indicated a thorough investigation and root cause analysis process there was evidence ward staff repeatedly failed to follow established care and treatment policies or to implement specific care pathways. Although specialists, such as tissue viability nurses, were responsive in providing additional support and training to staff there were unresolved themes in serious incident outcomes that indicated a lack of governance in the use of care pathways and related staff competencies.

Senior divisional staff used a risk register to assess the severity of risks to the service and to measure and track control measures in place. As of February 2018 medical care services at Pilgrim Hospital had 34 live risks on the risk register. We reviewed all of the risks and found variable standards of review. For example some risks had been in place for significant periods of time with no substantive controls in place and no evidence of resolution. For example a risk relating to a lack of storage on ward 7b had been escalated in 2010 and entered in the risk register in 2016. There was no evidence of progression and the most recent note was seven months old and noted the divisional team needed the input of the ward manager. This risk reflected limited cross-team learning from a fire in the hospital in 2017, which found the ward had not undergone a fire risk assessment. The risk of poor storage in the context of fire safety had not been identified.

Another risk had been raised in 2011 that related to a potential for an echo machine to overheat. This risk had been live, without resolution, for 7 years although a note on the record stated it could be resolved within the directorate. The last documented update to this risk had been recorded in 2014.

There was evidence some risks had resulted in improvements to patient care and quality standards. For example in January 2017 the AMU team identified over 900 delayed electronic discharge documents (eDDs) that had not been completed due to pressures on staffing and capacity. The AMU team had documented regular updates to this risk and had reduced the number of delayed eDDs to 50 in January 2018. The senior team had implemented a new standard operating procedure that meant patients could not be discharged without an eDD in place except during periods of exceptional demand.

Senior nurses described the management of risk relating to a shortage of nurses as poor. This related to a new ‘cohort interview’ system the trust had implemented that interviewed and recruited
nurses centrally and then deployed them to individual wards. For example ward 6b had not been allocated any new nurses in the previous six months despite ongoing short staffing.

As part of the trust’s vision and strategy and improvement programme a wide-ranging ward accreditation scheme had been implemented. A team of quality matrons used a quality assessment for each ward that considered knowledge and performance in 13 key areas such as safeguarding, identifying deteriorating patients and end of life care. Wards were awarded a status based on the red, amber, green system and were required to submit an action plan targeting specific improvements. The first wave of accreditation had been completed with four wards at amber status and four wards at red status. Three wards achieved green status for their work in end of life care and two wards each achieved green status for continence management. The second wave of accreditation assessments had started at the time of our inspection and the first available results indicated significant improvement. This was for wards 6a and 6b, which had moved from red status to amber status and had achieved green status for seven criteria including safeguarding. All of the staff we spoke with were positive about the accreditation programme and said it had helped them to identify where they needed to improve and to get help in achieving this. This was a substantive programme of work that demonstrated considerable focus on improving patient safety and outcomes.

Each ward had an assurance board that included the latest recommendation result from the NHS Friends and Family Test as well as examples of positive and negative feedback from patients, relatives and visitors.

There was inconsistent use of ward meetings to review performance. The most recent meeting on ward 8a had taken place four months previously and only the ward sister had signed to indicate they had read the minutes and outcomes. Staff on ward 7b told us they were too short staffed to hold meetings. Matrons told us they had regular meetings with each other and with the head of nursing and director of nursing. Senior staff nurses told us weekly meetings were scheduled but frequently cancelled.

We saw well-coordinated implementation of the business continuity plan and incident escalation processes during a period of extreme weather. This included effective liaison with the police service and on-site accommodation for staff that could not safely get home. Doctors prescribed medicine to staff to enable them to safely remain in the hospital; this also meant patients received continuity of care despite significant disruption to travel in the local area.

Staff in the ACU had prepared a ‘safety express’ noticeboard for staff. This was a quick-reference guide to a number of processes that each individual should be aware of and adhere to. This included the deteriorating patient policy, the safety dashboard, scrutiny of peripheral cannulas and using lifting equipment safely.

**Information management**

There was a lack of confidentiality relating to staff records on ward 8a as sickness reporting information, including the reason for individual spells of sickness, were readily available to all staff.

Each ward had an electronic patient information display system that we saw displayed personal details about each patient, including their name and date of birth. Staff routinely left the screens on throughout the day, which meant anyone in the ward could access personal information. In addition we observed board roads took place in most instances within earshot of bed bays, which meant patients could hear confidential information about others on the ward.
We found patient notes were stored in open-access trollies at the entrance to bed bays on wards or adjacent to nurse stations. During visiting hours there was a significant risk unauthorised people could gain access to confidential information, particularly in very busy wards that were short of staff.

The frailty nurse practitioner had completed training to be able to use the electronic patient records system used by local GPs and community providers, which also enabled them to carry out the Montreal Cognitive Assessment and confusion scores. However, only one computer in the hospital was equipped to access this system, which restricted the ability of the team to complete records in a timely manner. Although the clinical director, head of services and head of nursing had been supportive of the pilot there was limited engagement from the rest of the senior team and a lack of communication with regards to expectations and the future of the service. The frailty team were not included in daily bed meetings, which meant their impact on access and flow was limited.

**Engagement**

The trust had undertaken a six month period of engagement with staff to identify understanding of the 2021 strategy and transformation plan. This identified broad support for the overall programme with 98% of staff agreeing that the trust’s services needed to change. Engagement indicated the trust needed to increase the confidence of staff teams in the transformation vision as 41% of staff said they believed the trust could succeed in transformation. Key feedback from staff included a need to introduce a rehabilitation ward at each hospital and move services for the management of patients with long term conditions into the community. The trust planned to hold a large-scale launch event for the strategy that would include how they planned to address staff suggestions, concerns and feedback.

A patient experience committee maintained oversight of service improvements that could be submitted by any ward or clinical department and ensured improvements were based on need and evidence. The patient experience committee was in the process of reviewing a substantial overhaul of end of life care services that included the implementation of a national care programme, improved bereavement services and a two-year collaborative project to establish patient feedback.

The ward sister on ward 7b had introduced a weekly blog for staff to improve communication and engagement, which all of the staff we spoke with said they found useful.

Although staff said they had completed a staff survey they were not aware of any outcomes or learning from this. This included a clinical nurse educator who said the trust had provided no feedback or actions from the last staff survey and a matron who was unaware of the results from their teams.

The AMU team had been nominated for a team of the year award, which staff told us had boosted morale and lifted their spirits.

The clinical educator on wards 6a and 6b had introduced a ‘mentorship matters’ meeting each month as a strategy to recognise and celebrate the work of the mentors in the hospital. This also enabled mentors to share learning and good practice with each other. The ward managers for these areas had increased engagement with their teams following a period with leadership absence. For example one ward manager wrote personally to staff to acknowledge good practice or to ask them to think about areas for improvement.

Senior nurses described an improvement in engagement in the previous three years. For example the director of nursing held a weekly band seven nurse meeting to improve communication and to
enable each nurse the opportunity to provide feedback. We asked senior nurses about this and in all cases we received positive feedback.

**Learning, continuous improvement and innovation**

The trust had a five-year vision to achieve an improvement in standards across five key areas by 2021. As part of this each ward had a large format poster display that the team used to display their top three improvements and top three goals that were in the context of the 2021 vision. The chart had a space for a daily topic or target for staff that was discussed during morning safety briefings, handovers or huddles. The senior ward nurse updated this as the team progressed towards their goals. For example the team on ward 6b had identified areas for improvement as caring for patients at risk of self-harm as a result of dementia and safeguarding vulnerable adults.

Audit plans indicated a continual drive to identify opportunities for improvement and innovation in care and treatment. For example an occupational therapy audit planned for 2018 would review how patients experienced visual changes following a stroke and a physiotherapy audit was reviewing a substantial number of referrals to identify how inappropriate referrals could be reduced in future. The dietetics team audit programme focused on patient outcomes and included an audit of specific diet textures and improving the management of oncology referrals.

The haematology-oncology matron was working with the divisional team to plan future improvements to the service. This included a protected bed space at the hospital for patients who tested positive for sepsis and the introduction of an acute assessment area for oncology patients.

Senior staff did not believe the operating model or staffing pressures of the hospital were sustainable and that recruitment was increasingly challenging. Although the director of nursing regularly visited the site senior staff said the medical director rarely attended and the trust’s vision and strategy did not fully apply to this site. This was echoed by senior ward nurses. One individual said, “We are all burnt out. Some of us are working 80 hours a week and getting ill in the process. It’s not sustainable and we’re just waiting for it to give way.” An emergency care matron had responsibility for the AMU but staff told us they did not have time to come to the unit due to the pressures on the emergency department, which was also in their remit. In addition three matrons had been in post since August 2017, which resulted in a lack of support for the senior nurse team on the unit.

A clinical educator demonstrated a proactive, energetic approach to learning and development that they used to build and maintain momentum and enthusiasm. They had received 100% positive feedback from the most recent student nurse cohort and a plaudit from the National Medical Council as a point of best practice.
Facts and data about this service

At Pilgrim Hospital Boston there are 126 surgical inpatient beds across five wards and 18 day case beds. There are 11 theatres carrying out elective and emergency general surgery, vascular surgery, urology and orthopaedic surgery.

Details of the surgical wards are shown below:
Pilgrim Hospital Boston

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Specialties provided</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 3A</td>
<td>Elective orthopaedics</td>
<td>23</td>
</tr>
<tr>
<td>Ward 3B</td>
<td>Trauma and orthopaedics</td>
<td>29</td>
</tr>
<tr>
<td>Ward 5A</td>
<td>General surgery</td>
<td>29</td>
</tr>
<tr>
<td>Ward 5B</td>
<td>Vascular surgery</td>
<td>25</td>
</tr>
<tr>
<td>Day Care Unit</td>
<td>N/A</td>
<td>18</td>
</tr>
<tr>
<td>The Bostonian</td>
<td>General surgery</td>
<td>18</td>
</tr>
</tbody>
</table>

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

The trust had 46,974 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 13,731 (29.2%), 26,231 (55.8%) were day case, and the remaining 7,021 (14.9%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 90% for completion of the majority of mandatory training however some modules had a higher target which can be seen in the table below.

A breakdown of compliance for mandatory training courses from April 2017 to October 2017 for medical/dental staff in surgery is shown below:

Pilgrim Hospital – medical/dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>91</td>
<td>95</td>
<td>96%</td>
<td>90%</td>
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</tr>
<tr>
<td>Health &amp; Safety</td>
<td>87</td>
<td>95</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>86</td>
<td>95</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Name of course</td>
<td>Number of staff trained (YTD)</td>
<td>Number of eligible staff</td>
<td>Completion (%)</td>
<td>Target (%)</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------</td>
<td>----------------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>203</td>
<td>207</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>202</td>
<td>207</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>192</td>
<td>207</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>190</td>
<td>207</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>188</td>
<td>207</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>187</td>
<td>207</td>
<td>90%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>186</td>
<td>207</td>
<td>90%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>181</td>
<td>207</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>178</td>
<td>207</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>160</td>
<td>207</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>145</td>
<td>207</td>
<td>70%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>55</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>32</td>
<td>0</td>
<td>N/A</td>
<td>TBC</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The trust’s target was not met for six out of the 11 eligible training modules for nursing and health visiting staff at Pilgrim Hospital.

(Source: Routine Provider Information Request (RPIR) – Training)

The trust had an induction programme for permanent and temporary staff and a mandatory training plan. There was a combination of e-learning and face to face learning.

All nurses we spoke with were aware of what their personal mandatory training needed to be completed and knew how to access the electronic training modules.

The service was not meeting the trust target for mandatory training across all modules, especially for medical staff. However there were plans in place to improve the rates such as the provision of E learning. Staff told us they were often too busy to attend or there was a lack of staff.
Sepsis eLearning for all front line staff was recently introduced through mandatory training along with the introduction of an electronic sepsis screening and sepsis six bundle based around NICE and sepsis trust guidance.

Junior doctors informed us they had dedicated time for completion of mandatory training during their initial foundation year one (FY1 - foundation doctors on a two-year general postgraduate training programme) induction but senior house officers (SHOs), registrars and consultants were required to complete training in their own time. All FY1 and FY2 doctors received basic life support (BLS) and intermediate life support (ILS) training as part of their induction.

**Safeguarding**

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training from April 2017 to October 2017 for medical/dental staff in surgery is shown below:

**Pilgrim Hospital – medical / dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>80</td>
<td>95</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>79</td>
<td>95</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>68</td>
<td>95</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>68</td>
<td>95</td>
<td>72%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>36</td>
<td>54</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital the 90% target was not met in any of the safeguarding training modules for which medical and dental staff were eligible.

A breakdown of compliance for safeguarding training from April 2017 to October 2017 for qualified nursing and health visiting staff in urgent and emergency care is shown below:

**Pilgrim Hospital – Qualified nursing & health visiting staff (Qualified nurses)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>194</td>
<td>207</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>194</td>
<td>207</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>192</td>
<td>207</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>192</td>
<td>207</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all safeguarding training modules for which qualified nursing and health visiting staff were eligible at Pilgrim Hospital.

(Source: Routine Provider Information Request (RPIR) Training)
Staff were able to explain how to escalate any safeguarding concerns. Staff had a clear understanding of safeguarding process, what constituted a concern and how to escalate this. Staff were aware of the safeguarding lead within theatres and to escalate concerns to them. Staff were aware of their responsibility in relation to female genital mutilation (FGM).

**Cleanliness, infection control and hygiene**

The trust had guidelines for the management of patients with *Clostridium difficile* (*C* Difficile) Infection and a guideline for the control of Methicillin-Resistant Staphylococcus Aureus (MRSA).

The trust held infection prevention surveillance meetings monthly which were site specific. Performance for April 2017 to February 2018 showed there was no *C. difficile* or MRSA on the surgical wards at the Pilgrim hospital.

The meetings also monitored pseudomonas and legionella outbreaks and found an increase in positive results in some of the showers and hand basins. Actions were taken to remedy this.

It is a mandatory requirement to participate in the Nosocomial Infection National Surveillance Scheme (NINSS) study of Surgical Site Infection (SSI). Nationally all trusts are expected to provide a minimum of three months orthopaedic surveillance data of one of the orthopaedic options:

- Total Hip Replacements (THR)
- Total Knee Replacements (TKR)
- Repair of Neck of Femur

The trust submitted data to the surgical site infection surveillance service across the trust, and received reports into specialities. For orthopaedics this included every patient who had undergone the repair of neck of femur (NoF). The service had a consistently low rate of infection for NoF patients reported, and had completed two audits over the past two years to reassure themselves of compliance and accuracy.

In information provided to us, the trust stated they had participated in SSI surveillance for the past 12 months, with a rolling programme for fractured neck of femur and a month rotational programme for total hip replacement and total knee replacement. The data was collated by the nurse specialist for total hip and knee replacements. This data was uploaded to the public health England website. The data was provided to the infection control team through the Divisional reporting system.

The service had started to participate in a national programme sponsored by the NHS for clinical improvement. This was called the ‘getting it right first time’ (GIRFT) programme. The program identifies the surgical site infection rates of specific procedures within key surgical specialties. In August 2017 the surgical division had started to submit their data.

Results to date showed between November 2016 and May 2017 there had been 3.8% (four cases) surgical site infections for elective gall bladder surgery, 4.2% (two cases) gastro-intestinal surgery, 9.5% (two cases) and no surgical site infections for inguinal hernias. Actions were taken to improve these and we saw data provided by the trust showed between May 2017 and October 2017 that these figures had improved with surgical site infection rates showing 1.4% (two cases) surgical site infections for elective gall bladder surgery, 4.2% (two cases) and no surgical site infections for gastro-intestinal surgery and inguinal hernia surgery.

There was awareness amongst staff about infection control and we observed staff washing their hands, complying with the ‘bare below the elbows’ policy and using hand gel. We observed all
staff using hand gel when entering and exiting the wards. Adequate supplies of personal protective equipment including gloves and aprons were available and we saw staff using these appropriately.

Hand hygiene audits for the service were carried out monthly. There were five areas of hand hygiene audited; before patient contact, before a sterile procedure was initiated, after contact with bodily fluids, after contact with the patient and after contact with the patient environment. Overall at the time of our inspection the surgical division scored 93% for compliance with these practices.

There were dispensers with hand sanitising gel situated around the wards and operating theatres as well as the main entrance to wards and inside rooms. Hand washbasins were equipped with soap, disposable towels and sanitizer. This is in line with best practice.

There were side rooms available on each of the wards we visited in order to isolate patients if they had an infection.

Patients awaiting elective surgery were admitted through the day surgery unit so as not to come in contact with those patients already having had surgery. This was in line with best practice.

The service had a standard operating procedure admission criteria for patients admitted and outpatient to elective orthopaedic wards (2017). This laid out the procedures for reducing the incidence of infection due to mixing of both elective orthopaedic patients and medical outliers. However at the time of the inspection this was not in use as elective orthopaedic patients were cared for on the Bostonian ward due to the high numbers of medical outliers.

Medical outliers is a term used when there is a lack of beds in medical wards and patients are placed in other wards mainly surgical wards.

The service had a policy for the management of sepsis six and staff were aware of the policy. Sepsis six guidance was displayed on notice boards at the entrance of each ward and department.

The trust told us In addition to the core e-learning for the sepsis module, over the last year staff had been trained either on a 1:1, in small groups or as a group session around Sepsis six. The Sepsis e-Learning module covered all aspects of the sepsis care bundle and Sepsis six.

There was a training video on the intranet for support on how to complete sepsis six electronically.

We saw curtains were used around beds. These were clean and stain free with a date of first use indicated on them. Linen storage areas were tidy and there was sufficient clean linen available.

All of the equipment we examined such as vital sign monitors, mobile computers and infusion pumps were visibly clean. We also saw ‘I am clean’ labels in use to indicate when equipment in storage was cleaned.

**Environment and equipment**

The department participated in the national patient-led assessment of the care environment (PLACE). PLACE enables assessors who have experience of the hospital environment to review areas used to care for patients against five areas: cleanliness; privacy; condition, appearance and maintenance; dementia and disability. The surgical division scored 95% for the condition, appearance and maintenance of the patient environment at the hospital.

Resuscitation equipment, for use in an emergency was checked daily by one of the senior nurses. Equipment was documented as complete and ready for use. We reviewed documentation which showed that trolleys were checked on a daily basis. However we did see one trolley had drugs that were passed their expiry date. This was brought to
the attention of senior staff at the time of our inspection.

There were 11 operating theatres over two floors. The ground floor had six theatres with the remaining five on the second floor. The ground floor deals with emergency procedures including trauma, also delivering elective orthopaedics, gynaecology, breast and ophthalmology. The second floor deals with general surgery, urology, ENT and vascular, also running some ophthalmology lists. Paediatric surgery is delivered by relevant speciality area.

In theatres we found that equipment was kept in good order and stored neatly. Theatres were found to be tidy and well organised. All portable electrical testing (PAT) of appliances had taken place and were in date. In the equipment store, items were well organised and labelled. Infusion pumps were tested and in date.

We observed a procedure on the all-day list of a consultant orthopaedic surgeon. The standard of equipment in theatre was good. The operating theatre was clean, light and spacious, with laminar air flow. Laminar flow in theatres is used to reduce the number of infective organisms in the theatre air by generating a continuous flow of bacteria free air. Air filters are installed on parts of the operating theatre walls.

Consultant orthopaedic surgeons use one standard hip prosthesis and one knee prosthesis which ensured a more effective use of surgical implants.

We observed there was appropriate bariatric equipment in the surgical wards. Bariatric equipment is used for care of patient who are overweight.

Instruments were cleaned and sterilised off site and there was a delivery of instruments three times a day. Staff told us there were no issues with the lack of surgical equipment.

At the time of our inspection there had been severe weather warnings which restricted the transfer of surgical equipment from the main sterilising unit at the Lincoln site to the Pilgrim site. We observed staff checking which instruments were needed for the following days surgery and ensuring there were sufficient instruments to carry out scheduled operations. This was carried out in an organised and professional manner.

Operating theatres followed the ‘clean to dirty’ pathway and there was a back corridor in which clinical waste and domestic waste was removed. Corridors were clean with no clutter.

Sharps bins were in use in the operating suites and were disposed of as per policy. Each operating theatre had its own equipment trolley housing tubes, masks and scopes for assisting patients to breathe.

There was no rolling programme for the replacement of theatre equipment apart from anaesthetic machines. Equipment needing replacing had a service contract and was documented on the directorates risk register. However we saw the operating theatre risk register for Pilgrim hospital showed three risks one of which was a lack of a rolling programme for operating theatre tables.

A register of theatre equipment was held with the electrical and biomedical engineering department. We asked the trust for a copy of equipment maintenance lists for theatres but we did not receive these in the required timeframe for inclusion this report.

We visited the pre assessment unit and found some cupboards containing syringes and needles were left open. Staff coats and scarves were hanging by a sink in full view of patients. Food and water belonging to a member of staff were left on a worktop next to blood cards ready for the next patient. This was not an appropriate way to manage a patient environment.

We visited the day surgery unit which comprised of three six trolley bays and one four trolley bay.
This was clean and well laid out.

**Assessing and responding to patient risk**

There were a number of initiatives in place to identify and assess risks to patients on the wards and departments such as ward rounds, board rounds, the golden hour, clinical cabinets and safety quality matrixes. However these often happened at the same time which resulted in the trained ward staff not being able to attend all ward rounds.

The matron for general surgery, vascular surgery and orthopaedics would visit any of their wards and carried out on the spot audits of patient’s notes, observations and medication administrations. This was called the golden hour. Immediate feedback was given by the matron so learning could be implemented effectively.

Staff also participated in a morning huddle where patient’s needs were discussed and high risk patients were identified. Staff would be told if there were any patients who were distressed overnight so they could review them as soon as the huddle had been completed.

Observations and a review of documents confirmed a minimum of four hourly national early warning scores (NEWS) were carried out and recorded for all patients. NEWS scores were also displayed electronically on a white board near the nurse’s station. Staff told us this was easy to use but was dependent upon the staff keeping it up to date. We checked the accuracy for three patients and all data was correct. If a patients score was five or above the screen would flash red and the critical care outreach team would visit any patients with a NEWS of five or above.

The service had developed a ward accreditation scheme which measured the quality of care delivered to patients on the wards. The 15 areas assessed included identifying the deteriorating patient, falls prevention, nutritional support, risk management and pressure ulcer prevention. Wards 3a and 5b were included in this accreditation process. Both wards showed areas that could be improved and actions were put in place to make improvements.

Patients who were stepped down from the ICU to a general ward would be followed up by the critical care outreach team (CCOT). The CCOT would provide advice on their patients and would look after patients who had chest drains in place.

Patients having an epidural during and after surgery were cared for on the intensive care unit (ICU) until the epidural was removed. An epidural is an injection in the back to stop feeling pain and is given prior to surgery for some patients rather than a general anaesthetic. There were no patients nursed on the general wards with an epidural in place.

Patients having a peripherally inserted central line (PICC line) would be visited after their surgery by the vascular nurse specialist. A PICC line is a small catheter inserted into a large vein and used for giving blood, antibiotics and other fluids.

Staff in the operating theatres and the day surgery unit followed the World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery. Compliance against the WHO checklist was mandatory and audited monthly. This demonstrated compliance by specialty, anaesthetist, and consultant. We saw a dashboard demonstrating monthly compliance showing outcomes and trends for the year. The latest report for September 2017 showed 100%. These outcomes were discussed at specialty governance meetings and directorate performance meetings.

We saw ward rounds on the surgical wards were disorganised this was due to a number of surgeons arriving on the wards either late or at the same time. This led to nursing staff not being able to accompany all consultants on their ward rounds. There was a potential for communication
to be missed which may cause risks to patients. Senior staff were aware of this and told us this was due to board rounds taking place at 8.30am. We understood this was to be reviewed.

We observed a well performed safety briefing, pre–list in theatres, with good staff involvement. There was good analysis performed at the safety huddle, which also considered the next day’s requirements of equipment and staff.

Ward 5B was the designated surgical ward where patients with a tracheostomy were looked after. Staff had been trained to look after these patients and we saw there was always one member of staff on each shift that could care for these patients. However there had been no patients with a tracheostomy on the ward for over a year. Staff continued to have updates from ICU staff in order to keep their practice up to date.

In pre assessment, staff described good escalation processes to the consultant and anaesthetist if concerns were identified. Consultant anaesthetists had one session per week to review high risk patients and check patient notes prior to surgery. Nursing staff would email issues to the anaesthetists but we were told they did not often receive a reply.

The main operating theatres did not have its own blood bank where blood would be kept for patients undergoing major surgery. However the trust had a Massive Rapid Haemorrhage Protocol dated May 2017 which outlined processes to be carried out if a patient experienced a massive bleed. Staff told us all blood samples were obtained at preoperative assessment in readiness for usage. There had been no incidences of cancelled operations due to the lack of blood.

Stop before you block posters were displayed in all anaesthetic rooms to remind anaesthetists and staff to check the correct side a patient was to receive regional anaesthesia. However these were not in a prominent position for all staff to see. The stop before you block is a national safety campaign aimed at reducing the incidence of inadvertent wrong-sided nerve block during regional anaesthesia.

### Nurse staffing

The trust reported their registered nursing staff numbers, as of October 2017, as shown below. For all sites there were 558.9 whole time equivalent (WTE) planned staff and 471.8 WTE staff in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>51.2</td>
<td>43.8</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>258.1</td>
<td>226.3</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>19.2</td>
<td>15.6</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>230.4</td>
<td>186.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

From November 2016 to October 2017 the trust reported a vacancy rate of 16.3% for nursing and midwifery staff in surgery. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>11.5</td>
<td>12.1</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>11.5</td>
<td>15.6</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>11.5</td>
<td>10.5</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>11.5</td>
<td>18.4</td>
</tr>
</tbody>
</table>
Vacancy rates at Pilgrim Hospital was higher than the trust target of 11.5%.

*(Source: Routine Provider Information Request (RPIR) Vacancy)*

From November 2016 to October 2016 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 6.6% for qualified nursing and health visiting staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate for nursing and midwifery staff is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>1.0</td>
<td>20.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>26.7</td>
<td>20.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>0</td>
<td>20.0</td>
<td>0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>20.2</td>
<td>20.0</td>
<td>7.8</td>
</tr>
</tbody>
</table>

The turnover rate for all sites was within the trust’s target of 20% for an individual staff group.

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

From October 2016 to September 2017 United Lincolnshire Hospitals NHS Trust reported a sickness rate of 4.5% for nursing staff in surgery. The trust’s target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>4.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>3.9</td>
</tr>
</tbody>
</table>

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

**Bank and agency staff usage**

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 11.5% with a further 2.6% of shift remaining unfilled. A breakdown by staff type and location is shown below:

**Pilgrim Hospital Boston**

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>2,228 (6.0%)</td>
<td>1,468 (3.9%)</td>
<td>658 (1.8%)</td>
<td>37,373</td>
</tr>
<tr>
<td>Unregistered</td>
<td>4 (0.0%)</td>
<td>2,321 (11.3%)</td>
<td>664 (3.2%)</td>
<td>20,573</td>
</tr>
</tbody>
</table>

4% of all shifts were filled by agency staff and 7.5% of shifts were filled by bank staff. Unregistered nursing shifts were mainly filled by bank staff whilst there were similar proportions of agency and bank staff used to fill registered nursing shifts.

*(Source: Routine Provider Information Request (RPIR) Nursing bank agency)*

The Safer Nursing Care Tool was used to collect staffing information. We saw staffing on the wards conformed to the one registered nurse to a maximum eight patients guidance suggested by the National Institute for Health care Excellence (NICE).
Fill rates were collected and uploaded monthly to UNIFY as per national policy. These were then sent daily to the senior nursing team and broken down by substantive, bank and agency fill rates. Fill rates were published on the ward’s quality and safety board’s daily so patients and relatives could see them. Fill rates were also reported to the trust board monthly in the nursing and midwifery workforce paper. Staffing levels were also triangulated with quality and safety on a monthly basis through the ward health check.

We saw staffing levels (planned and actual) were displayed at the entrance to all wards.

We saw ward 5A displayed their staffing levels with five trained staff to cover the morning shift, five in the afternoon and three overnight which was the same as the planned staffing levels. Trained staff were supported by four health care support workers (HCSWs) in the morning, two in the afternoon and two overnight.

Staffing on the operating theatres conformed to the Association for Perioperative Practice (AfPP) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. However there were a number of theatre vacancies. For example there were 10.25 whole time equivalent (WTE) band five vacant posts, 3.75 WTE band two posts and 2.50 WTE orderly band two vacant posts.

Senior staff within the operating theatres had recently changed. Originally there were three band seven staff to oversee the two operating theatre suites. The change had resulted in having one band 8a theatre pathway manager in addition to a matron, a band seven on one floor and a band six on the other floor. The band six was primarily a nurse educator.

Staff on the day surgery unit comprised one band seven (unit manager), four band five nurses; four band two nurses and two housekeepers.

Staff told us recruitment of new staff was carried out using a cohort process. Staff found this a lengthy process and took too long. Staff also felt they had no choice as to choosing whether certain staff would fit into the team dynamics.

**Medical staffing**

The trust reported their medical and dental staff numbers, as of October 2017, as shown below. For all sites there were 391.5 whole time equivalent (WTE) planned staff and 348.5 WTE staff in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>53.0</td>
<td>47.0</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>176.2</td>
<td>165.6</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>158.3</td>
<td>131.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

From November 2016 to October 2017 the trust reported a vacancy rate of 12.0% for medical and dental staff in surgery. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>12.0</td>
<td>14.9</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>12.0</td>
<td>9.3</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>12.0</td>
<td>9.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>12.0</td>
<td>14.2</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital the vacancy rate was higher than the trust target of 12.0%.
From November 2016 to October 2017 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 12.2% for medical and dental staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust's turnover rate for medical and dental staff is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>3</td>
<td>20.0</td>
<td>10.4</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>9.6</td>
<td>20.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>0.0</td>
<td>20.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>11</td>
<td>20.0</td>
<td>15.0</td>
</tr>
</tbody>
</table>

The turnover rate for all sites was within the trust's target of 20% for an individual staff group.

From October 2016 to September 2017 United Lincolnshire Hospitals NHS Trust reported a sickness rate of 1.7% for medical and dental staff in surgery. The trust's target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>4.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Sickness rates for medical and dental staff from October 2016 to September 2017 were below the trust's target of 4.5% at all sites.

Bank and locum staff usage

The trust was unable to provide the appropriate data for us to make analyse.

Bank and locum staff usage

As of August 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher.
Staffing skill mix for the whole time equivalent staff working at United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>31%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>9%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

The trust continued to have a lower number of consultants (42%) than the England average of 48%.

Medical staff carried out 8.30 am ward rounds Tuesday, Thursday and Friday. Monday and Wednesday ward rounds were later (9.30) due to meetings and teaching sessions.

For general surgery there were four colorectal surgeons and two general surgeons with a 1:6 on call rota.

There were 22 anaesthetists who covered a 1:8 ICU rota and 1:11 general anaesthetic rota. One of the 11 anaesthetists covered the pain clinics.

There were eight orthopaedic consultants with a 1:10 four day rota. This was supplemented by an orthopaedic advanced nurse practitioner and three trauma nurse practitioners. Each of the consultants had a speciality within orthopaedics. For example two covered hip replacements, two covered upper limb and elbow surgery, two covered trauma and orthopaedic surgery and two covered knee revision surgery.

There was a registrar middle grade rota providing 24 hour cover seven days a week for the surgical wards.

Records

We saw patient records were stored securely on the wards although records in the pre assessment unit were left unlocked. We had to prompt staff to secure the records.

We saw records of a patient who had a DoLS in place. These were comprehensive and showed full multi-disciplinary team (MDT) involvement in the patients care.

Staff told us and we saw care plans had improved since the last inspection. Care plans were more specific to the patient’s needs.

We looked at case notes containing a do not attempt resuscitation (DNAR) forms. These were fully completed and were dated and signed by the medical team.
We saw two some poorly completed fluid charts; there were no totals and no record of the patient being offered fluids.

Local documentation audits were carried out on the wards monthly and actions from these were discussed at team huddles. Results from a recent NHS litigation authority (NHSLA) audit 2017 showed 85% compliance with multi-disciplinary record keeping. There were a number of recommendations which the trust were actioning.

**Medicines**

Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges on the ward. We saw fridge temperatures were regularly checked and recorded. The monitoring of medicines requiring refrigeration was regularly checked and the correct paperwork was used to record these temperatures. The temperature monitoring charts were compliant line with March 2005 Royal Pharmaceutical Society; The Safe and Secure Handling of Medicines: A Team Approach.

Medicines were stored in treatment rooms using cabinets that required an electronic access system to open them and allowed only authorised staff to access them.

Some prescription medicines were controlled under the Misuse of Drugs legislation 2001 and called controlled drugs (CDs). We examined the CD cupboards and found that storage was appropriate with no other items in the cupboards. Balance checks were carried out twice daily in theatre in line with trust policy.

The emergency equipment was clearly seen; however there were boxes that were out of date and required replacement. The emergency boxes were updated during the inspection.

Hypo kits were available for the emergency treatment of hypoglycaemia. The kits were checked daily and sealed with a tamper evident seal. Hypoglycaemia is the treatment of low blood glucose levels.

We saw nurses administering medication, checking doses and names. Both nurses wore red aprons to indicate they were carrying out medication rounds and did not need disturbing. This reduced the chance of medication errors occurring.

We checked 12 medication records which were completed comprehensively, dated, signed and had no missing doses. We saw allergies to medications were noted on the charts.

Staff knew about the five rights of medication administration. One of the recommendations to reduce medication errors and harm is to use the “five rights”: the right patient, the right drug, the right dose, the right route, and the right time.

We saw on ward 5B, intravenous potassium fluids were not segregated from main intravenous fluids in line with the National Patient Safety Agency (NPSA) guidance. The use of potassium through a vein can be highly dangerous and storage needs to comply with NPSA guidance. We informed staff about this at the time of our inspection and staff moved the potassium boxes to another area.

The service carried out quarterly controlled drugs audit in the operating theatres to ensure controlled drugs were stored and checked appropriately.
Pharmacy staff were available on surgical wards every weekday, to complete medicines reconciliation, check discharge letters and supply medicines. Patients were not given the opportunity to self-administer when appropriate.

In recovery we observed properly locked and organised controlled drugs management. The non-controlled drugs cupboard was left unlocked throughout the day but was supervised by the presence of someone at the desk.

**Incidents**

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

From January 2017 to December 2017, the trust reported one incident classified as a never event for surgery. This was a retained foreign object post procedure. This related to the Lincoln Hospital site.

In accordance with the Serious Incident Framework 2015, the trust reported 69 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Pressure ulcer meeting SI criteria with 26 (37.7% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 10 (14.5% of total incidents).
- Slips/trips/falls meeting SI criteria with 10 (14.5% of total incidents).
- Treatment delay meeting SI criteria with 10 (14.5% of total incidents).

Site specific information can be found below:
Pilgrim Hospital

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Total incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>12</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>6</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>5</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>3</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>3</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

All staff we spoke with told us they felt confident to report incidents and were encouraged to be open and honest. They felt they had a good understanding of what and how to report.

Incidents such as theatre cancellations, falls, pressure ulcers, lack of equipment and inappropriate outliers would be reported as an incident. Staff told us there was a good culture for reporting incidents. These would be investigated by the senior sister, discussed at weekly meetings and included on the monthly governance meetings.

During our visit we observed examples of incidents reported and escalated by staff from a range of disciplines who worked at different levels across the service. We saw that incidents were openly discussed by staff with patients and their relatives where applicable.

Safety thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported 49 new pressure ulcers, 31 falls with harm and nine new catheter urinary tract infections from November 2016 to November 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at United Lincolnshire Hospitals NHS Trust

![Graph showing prevalence rate of pressure ulcers over time]
The rate of pressure ulcers recorded in the patient safety thermometer has varied over time but there has been no upward or downward trend over the period. The rate of falls recorded has fallen over the period and the rate of urinary tract infections in patients with a catheter (CUTIs) has remained similar.

(Source: NHS Digital)

We saw the day surgery safety thermometer which was displayed on the unit showed 100% compliance with hand hygiene and 100% no trips or falls. However we saw information on the display board on ward 3B was out of date and was last updated in November 2017. This meant patients and staff could not see trends in performance.

The trust provided us with information relating to a monthly safety quality dashboard for the Pilgrim hospital. Staff told us this was a 31 item ward health check and included areas such as drug administration, patient observation checks, equipment checks, tissue viability checks and sepsis updates. Data for the surgical unit showed the information collated was either incomplete or had not been carried out. For example the resuscitation equipment checked daily (0%), fridge temperatures checked daily and recorded (0%), sepsis information (not recorded). However there were 100% scores for areas such as CDs checked daily, medicines checked daily, patient observations completed on time and allergies documented. Actions were in place to address areas of poor compliance.

The 2017 audit of venous thromboembolism (VTE) for patients undergoing elective knee and hip replacement surgery showed VTE risk assessment on admission had decreased in comparison to previous audits. The audit also showed that proper documentation of mechanical prophylaxis was poor, conveying VTE information through VTE booklets/leaflets still needed improvement. Recommendations were made and VTE would be re-audited to ensure improvements were made.

Is the service effective?

Evidence-based care and treatment

Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies

Policies, protocols and standard operating procedures were available on the hospital’s intranet. We saw staff used the intranet and accessed the relevant documents. Wards and departments also kept hard copies of the guiding documents so that staff could access these in the event of IT
downtime. All policies we reviewed had a document owner, a date of approval and a date for review to ensure the most up to date version was referred to.

We saw minutes of meetings where each directorate reviewed new and existing National Institute for Health and Care Excellence (NICE) guidance.

Progress with National Safety Standards for Invasive Procedures (NATSSIPs), were reported on in the monthly performance report.

We reviewed patient records during our visit and saw patients’ care was planned and delivered in line with evidence-based guidelines such as NICE and the Royal Colleges.

Pilgrim hospital housed a clinical research centre which staff from the surgical departments were involved in. There were a number of research studies that covered vascular surgery, orthopaedic and general surgery. The surgical teams took part in national research and as such shared their data to improve patient outcomes.

Staff across the surgical division used a number of integrated care pathways such as the hip management pathway. This ensured patient were getting evidence based care.

**Nutrition and hydration**

Staff used national guidance tools to assess patients’ hydration and nutrition needs that were set out in an up to date trust nutrition and hydration policy.

The trust collected data to inform compliance with food standards. These standards included screening of patients at risk of malnutrition using a national malnutrition universal screening tool (MUST). The MUST score was completed within 24 hours of admission, and then weekly or more frequently if necessary. If the assessed score was greater than two, nurses referred the patient to the dietitians for a review. In all of the patient records we looked at we found these were completed by staff.

The national hip fracture audit 2017 showed 97% of patients in this group received a nutritional assessment which was better that the England average of 86%.

The dietitian would visit the wards weekly and offer advice where necessary. Staff on the wards were trained in giving patients total parental nutrition (TPN). TPN is the feeding of a patient through a vein, bypassing the usual process of eating and digestion. The patient would receive nutrients such as glucose, salts, added vitamins and dietary minerals.

**Pain relief**

Patients received adequate pain relief in line with the Core Standards for Pain Management Services in the UK (2015).and were cared for by specialist trained nurses.

There was a trust wide pain management team consisting of three specialist nurses who worked seven days a week across the trust.

Patients we spoke with told us their pain was being well managed. On arrival for planned surgery we were told pain was checked. Post-surgery patients told us that ward staff asked them regarding their pain levels. Patients described staff as responsive to call bells for assistance with pain management.

We saw Abbey pain tool was used to score patients pain. The Abbey Pain Scale is used as part of an overall pain management plan and is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.
Patient outcomes

We saw minutes of meetings where the anaesthetists audited compliance with the clinical governance guidance (CG65) ‘Hypothermia: prevention and management in adults having surgery’. The audit showed 91% compliance with the guidance.

The minutes also noted 75% compliance with the NICE guidance (NG45) ‘Routine preoperative tests for elective surgery’.

The national hip fracture audit 2017 showed 99% of patients in this group were seen by an orthogeriatrician which was better than the England average of 89%. The audit also showed that 96% of patients in this group received physiotherapy assessment prior to surgery which was better than the England average of 90%.

The national hip audit 2017 also showed 91% of patients in this group received prompt treatment which was better than the England average of 72%.

From September 2016 to August 2017, the trust had a lower than expected relative risk of readmission for elective admissions when compared to the England average. However when comparing the trust to the England average at specialty level (for the most common three specialties at the trust) Trauma & Orthopaedics patients had a higher than expected relative risk of readmission for elective admissions.

The trust had a lower than expected relative risk of readmission for non-elective admissions when compared to the England average. For all of the three most common specialties at the trust the relative risk of readmission for non-elective patients was lower than the England average.

Trust level

Elective Admissions – Trust Level

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

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Pilgrim Hospital

From September 2016 to August 2017, Pilgrim Hospital had a lower than expected relative risk of readmission for elective admissions when compared to the England average. However when comparing the hospital to the England average at specialty level (for the most common three specialties at the hospital) Trauma and Orthopaedics patients had a higher than expected relative risk of readmission for elective admissions.

The hospital had a lower than expected relative risk of readmission for non-elective admissions when compared to the England average. At specialty level (for the most common three specialties at the hospital) there was a higher than expected relative risk of readmission for non-elective Trauma and Orthopaedics when compared to the England average.

Elective Admissions - Pilgrim Hospital

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

Non-Elective Admissions - Pilgrim Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity
In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.2% which was within the expected range. The 2016 figure was 5.7%.

76.6% of patients had surgery on the day of or day after admission, which falls in the middle 50% when compared to other hospitals that participated in the audit. The 2016 figure was 79.3%.

The perioperative medical assessment rate was 56.4%, which falls in the bottom 25% of all hospitals that participated in the audit. The 2016 figure was 34.8%.

80.8% of patients were documented as not developing a pressure ulcer which put the hospital in the bottom 25% of all hospitals that participated in the audit. The 2016 figure was 90.8%.

The length of stay was 16.2 days, which falls in the top 25% of all hospitals that participated in the audit. The 2016 figure was 16.4 days.

(Source: National Hip Fracture Database 2016)

In the 2016 Bowel Cancer Audit, 69.0% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 78.9%.

The risk-adjusted 90-day post-operative mortality rate was 7.0% which was within the expected range when compared to other hospitals that participated in the audit. The 2015 figure was 6.9%.

The risk-adjusted 2-year post-operative mortality rate was 29.4% which was within the expected range when compared to other hospitals that participated in the audit. The 2015 figure was 22.6%.

The risk-adjusted 30-day unplanned readmission rate was 14.9% which was within the expected range when compared to other hospitals that participated in the audit. This was not reported in the 2015 report.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 75.1% which was a negative outlier when compared to other hospitals that participated in the audit. The 2015 figure was 85.6%.

(Source: National Bowel Cancer Audit)

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 5.8% for Abdominal Aortic Aneurysms, indicating that the trust was within the expected range when compared to other hospitals that participated in the audit. The 2016 figure was 4.1%.

For Carotid Endarterectomy, the median time from symptom to surgery was 11 days which was better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 3.5% which was within the expected range when compared to other hospitals that participated in the audit. The 2016 figure was 1.4%.

(Source: National Vascular Registry)

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The trust was not eligible for the 90-day post-operative mortality rate.
The proportion of patients treated with curative intent in East Midlands Strategic Clinical Network was 42.5% which was significantly higher than the national aggregate. This metric is defined at strategic clinical network level. The network can represent several cancer units and specialist centres. The result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

Pilgrim Hospital

In the 2016 National Emergency Laparotomy Audit (NELA), 84% of 133 cases had pre-operative documentation of risk of death. This was above the national standard of 80%.

70% of 91 cases had access to theatres within clinically appropriate time frames. This was below the national standard of 80%.

72% of 80 high-risk cases had a consultant surgeon and anaesthetist present in the theatre. This was below the national standard of 80%.

86% of 56 highest-risk cases were admitted to critical care post-operatively. This was higher than the national standard of 80%.

The risk-adjusted 30-day mortality was 12.1% based on 133 cases. This was within the expected range when compared to other participating trusts.

(Source: National Emergency Laparotomy Audit)

The anaesthetic department had reviewed its practice with regards to the non-compliance with a consultant anaesthetist present in the theatre for emergency laparotomies. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) booking form would be amended to include the National Emergency Laparotomy Audit (NELA) information so it would be more evident when a consultant anaesthetist was needed.

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 the proportion of groin hernia patients who reported an improvement following surgery was similar to the England average.

The trust performed worse than the England average for the proportion of patients who reported an improvement or a worsening following surgery for hip replacements, knee replacements and varicose veins.

(Source: NHS Digital)

We saw a robust audit schedule in place, we saw evidence of action plans to improve performance in patient outcomes, these were regularly reviewed.

Competent staff

Appraisal rates

The trust provided appraisal rates for staff who required an appraisal from April 2017 to October 2017. As most appraisals are carried out at the end of the financial year figures do not include all staff members. From April 2017 to October 419 staff were required to complete an appraisal with 83.5% of these having received an appraisal. This was lower than the trust target of 85%.

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

At Grantham and District Hospital 206 surgery staff were required to complete an appraisal with
79.5% of these having received an appraisal. This did not meet the trust target of 85%. 82.5% of qualified nursing and health visiting staff had completed an appraisal and 91.7% of medical and dental staff had received an appraisal.

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

At Lincoln County Hospital 471 surgery staff were required to complete an appraisal with 71.1% of these having received an appraisal. This did not meet the trust target of 85%. 75.6% of qualified nursing and health visiting staff had completed an appraisal and 100% of medical and dental staff had received an appraisal.

A split by staff group can be seen in the graph below:
At Louth Hospital 31 surgery staff were required to complete an appraisal with 51.6% of these having received an appraisal. This did not meet the trust target of 85%. 54.5% of qualified nursing and health visiting staff had completed an appraisal and 100% of medical and dental staff had received an appraisal.

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

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

There were a number of nurse practitioners employed at the service such as colo-rectal nurses, pain nurses, trauma nurses and surgical nurse practitioners.

On the surgery wards there were leads for individual areas. For instance safeguarding, infection control, tissue viability, nutrition and falls.

The bank staff we spoke with on the wards told us they felt well supported and had received induction in order to work on the wards. They had completed mandatory training.

All staff we spoke with told us they felt supported to attend training and were able to provide evidence of ongoing professional development. Nurses we spoke with had completed their NMC revalidation and felt they had been supported throughout the process. We saw a detailed induction programme for permanent and temporary staff.

The majority of noncompliance was due to long term sickness or maternity leave.

Newly qualified staff were given a competency based induction.

Multidisciplinary working

Nursing teams had access to medical staff and a range of allied health professionals, and generally described good collaborative working practices between the teams. Examples included working with clinical nurse specialists, tissue viability service for patients with pressure ulcers or complex wounds, and the critical care outreach team for patients at risk of deterioration or sepsis.
We attended a morning orthopaedic trauma meeting and observed examples of multi-disciplinary team (MDT) working. A consultant led the meeting, with physiotherapists and occupational therapists (OT) present, with them having opportunity to contribute to patient surgical planning and mobilisation post-operatively.

We observed cohesive team work in the operating theatres and there was full engagement of all team members during the WHO checklist.

Patient records demonstrated multidisciplinary input as well as nursing and medical teams. We reviewed 12 sets of notes and MDT input from physiotherapy, dietitians, occupational therapists, pharmacists and pain care team.

Orth geriatrician ward rounds took place for trauma and orthopaedic patients to improve patient assessment, management and treatment during inpatient stay. An ortho-geriatrician is a consultant with an interest in elderly orthopaedic care.

We saw staff from the re-enablement team visit patients in order to expedite their discharge home.

Information regarding a patients’ stay in hospital including the surgical procedure undertaken and prescribed medicines was sent electronically to their GP on discharge. Patients were also given a paper copy to take home.

One surgeon told us there was a lack of inter-consultant meetings where they could discuss difficult cases. This consultant told us they found it difficult to find someone to discuss specific clinical issues with. However senior medical staff made it clear there were mechanisms such as the twice weekly teaching sessions where more complex cases could be discussed.

**Seven-day services**

Consultant surgical and anaesthetic staff covered out of hours and orthopaedic consultants would carry out wards rounds six days a week and were available if needed on a Sunday. The trust did not collect information on patients seen within 14 hours of and admission by a consultant.

There was physiotherapy cover in the orthopaedic and trauma and vascular surgery wards at weekends; however, occupational therapy, dietetic, and speech and language therapy services were provided from Monday to Friday only, with no service at weekends.

Trauma meetings were held daily and were attended by the trauma coordinators, medical staff, theatre staff, x-ray staff and anaesthetists.

Pharmacy services were available between Monday and Friday 9am to 5pm and Saturday 9am to midday. There was an on call pharmacy team provided out of hours.

Physiotherapy and occupational therapy services were provided seven days a week and included on call and out of hour’s services.

The day surgery unit was open Monday to Friday, 7.30am to 10pm and diagnostic services were provided seven days a week.

The trust continued to have no out of hour’s laboratory or radiologist support which staff told us was a problem when meeting some of their cancer targets.

The mental health liaison team were available seven days a week.

**Health promotion**
Staff supported patients, and their relatives where appropriate, to manage their own health and wellbeing, and to maximise their independence following surgery. We saw enhanced recovery programmes that enabled patients to be actively involved in the recovery phase following surgery. Part of this pathway included encouraging patients to be as healthy as possible before their planned operation.

Patient records we looked at showed that staff in the surgical pre-assessment unit discussed eating well, exercise, relaxation, smoking cessation, and alcohol consumption and the importance of trying not to worry too much about the surgery. People who were smokers were referred to the smoking cessation services.

We observed one patient being pre-assessed prior to surgery which included the prevention of deep vein thrombosis and pulmonary embolism (blood clots in the veins and lungs) and what to watch for when they went home.

There were no leaflets relating to health promotion seen in the pre assessment clinic although staff directed patients to the internet for more information.

We saw patient leaflets on the wards such as diabetes care and how to look after foot ulcers. There was also information about home meals services where meals could be delivered directly to a patient’s home once they were discharge.

Patients diagnosed with an aortic aneurysm were screened regularly and given advice on smoking, diet and weight management.

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

Deprivation of Liberty safeguards training at the trust is completed as part of the Mental Capacity Act (MCA) level 2 training module. The trust reported that from April 2017 to October 2017 MCA level 2 training had been completed by 84.1% of staff within outpatients. This was lower than the trust target of 90%.

The trust set a target of 90% for completion of MCA level 2 training. A breakdown of compliance for MCA level 2 training for medical and dental staff in surgery from April 2017 to October 2017 is shown below:

**Pilgrim Hospital – medical and dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>59</td>
<td>95</td>
<td>62%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Pilgrim Hospital did not meet the trust target of 90% with particularly low training compliance compared to the other sites.

A breakdown of compliance for MCA level 2 training for qualified nursing and health visiting staff in surgery from April 2017 to October 2017 is shown below:
Staff told us and we saw MCA folders were available across all the wards we visited. Electronic copies were also available. This was in response to a request from the safeguarding team to provide some additional prompts/aids for staff to develop their knowledge of the MCA.

Staff told us the mental health team were easy to contact and would respond quickly when needed.

We saw the MCA folders contained request forms for urgent authorisation and standard authorisation. MCA nutritional and hydration needs, care plans for non-compliant and compliant patients.

The MCA care plans for compliant patients contained ward based medical treatment and investigations, administration of medicines, personal care, occupational therapy interventions, a Deprivation of Liberty (DoLS) scoping tool and an end of life care plan.

We saw the day case staff completed mental capacity assessments prior to the patient going to the surgical wards.

Staff told us they felt more confident about MCA and DoLS as there had been more support from the safeguarding team.

The safeguarding team reviewed the records monthly and audited notes to see whether chemical sedation had been used for patients needing sedation. These results were reported in the monthly activity report. The team worked with pharmacy staff so medicines were provided for each patient requiring chemical restraint by pharmacy staff. This improved a cross reference for safeguarding staff on those receiving chemical restraint.

A chemical restraint is a form of medical restraint in which a drug is used to restrict the freedom or movement of a patient or in some cases to sedate a patient.

We saw staff ask patients for their consent to have treatment and saw consent forms were completed and signed by two doctors.

The trust carried out a consent audit in breast and general surgery following the General Medical Council: Good Clinical Practice Guidance. The audit showed 100% compliance with all areas audited.
Is the service caring?

Compassionate care

The Friends and Family Test (FFT) response rate for surgery at United Lincolnshire Hospitals NHS Trust was 27% which was similar to the England average of 29% from December 2016 to November 2017.

A breakdown of response rates by site can be viewed below:

Friends and family test response rate at United Lincolnshire Hospitals NHS Trust, by site.

The percentage of patients that would recommend the hospital to friends and family is split by ward below:

(Source: NHS England Friends and Family Test)
The February 2018 FFT scores for recommending the hospital to friends and family showed:

Bostonian 80%
Ward 3A 82%
Ward 3B 100%
Ward 5A 80%
However the response rates were low:
Bostonian 22%
Ward 3A 16%
Ward 3B 25%
Ward 5A 23%

We saw the FFT information displayed on ward 3B was out of date and there were no paper cards for patients and relatives to record compliments.

Ward 5B displayed their FFT for January 2018 which showed 80% of patients would recommend their care to others and 91% rated the ward as clean.

The overall impression that we were given from patients and their relatives was that the service was a very caring. Most patients we spoke with during the inspection were very complimentary about the level of care they had received.

Patients told us staff took their time to stop and listen to them and were very respectful but they were very busy.

We saw staff talking with patients in a professional and considerate manner. Privacy and dignity was maintained for example; curtains were used when carrying out a procedure. Staff spoke with patients in a respectful manner.

A very caring attitude was observed by nursing staff in the recovery area.

**Emotional support**

Patients told us that medical and ward staff were emotionally supportive. We were told that staff understood the emotional sensitivity of patients awaiting and having just undergone surgery, and that staff were on hand to answer questions and were patient with people.

We saw staff caring for a patient who had a DoLS in place. Staff displayed understanding and a non-judgemental attitude towards this patient. We saw staff support the patient who became distressed in an open environment. Staff assisted them to maintain their privacy and dignity.

Patients told us ‘nurses were ever so good, nothing was too much trouble’, staff were absolutely brilliant.

We saw one patient who had a DoLS in place. We saw staff speaking quietly with the patient and staff had taken time to find out from the patients relatives what distressed the patient and what calmed them down. We were told by staff the safeguarding team were very impressed with staff approach to this patient.

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

Patients told us all their treatments had been explained to them and they could ask questions at any time about their care.

Staff told us and we saw patients were advised of the ward opening times at pre assessment, on admission and on discharge. Patient information leaflets were provided.

In addition on discharge we saw staff providing full advice on what to expect if there were complications, signs and symptoms and who to contact for advice. Also advise on who to contact for emergency situations was given to them.

We saw that staff communication with patients was good, with full explanations provided by staff to the patients and their relatives as to what they will be doing.
In the operating theatres, we observed a patient being prepared for a surgical procedure. Their surgery was described to them, along with what the process would be and the consultant checked whether the patient understood. This was carried out in a very clear way and was easy for the patient to understand.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Surgery services at Pilgrim hospital had been established to meet the needs of local people. Emergency theatres were available 24 hours a day.

Patients undergoing elective surgery were given appointments around their needs and requirements where possible. Appointments were booked via a central booking system that would contact the patient with a proposed date, patients then had the option to accept this date or request another. Staff reported where possible they would factor in the needs of the patient.

New roles had been established within the trust working under the supervision of registered nurses and medical staff, such as nursing associates and doctors’ assistants. Advanced surgical practitioners were also employed to help manage skills gaps and underwent training and assessment in advanced clinical skills including prescribing.

Information packs were given to patients at pre assessment that included information on VTE, anaesthetic, MRSA and fasting instructions. Patients we spoke with on surgery wards told us they were given useful information regarding their treatment, what was available and what to expect. Packs also contained telephone numbers for further advice.

**Average length of stay**

**Trust Level – elective patients**

From October 2016 to September 2017, the average length of stay for all elective patients at the trust was 2.6 days, which was lower than expected compared to the England average of 3.3 days.

When split by specialty the average length of stay for all three of the most common specialties (based on count of elective activity) at the trust was similar to the England average.

**Elective Average Length of Stay – Trust Level**

![Graph showing average length of stay for elective patients](image)

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

**Trust Level – non-elective patients**

The average length of stay for all non-elective patients at the trust was 5.2 days, which was...
similar to expected when compared to the England average of 5.0 days.

When split by specialty the average length of stay for two of the three most common specialties (based on count of non-elective activity) at the trust was similar to the England average. These were General Surgery and Urology. The average length of stay for non-elective Trauma and Orthopaedics patients was 7.3 days which was lower than the England average of 8.9 days.

**Non-Elective Average Length of Stay – Trust Level**

![Graph showing average length of stay for non-elective patients at different specialties.]

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

**Pilgrim Hospital - elective patients**

From October 2016 to September 2017 the average length of stay for all elective patients at Pilgrim Hospital was 2.9 days, which was similar to the England average of 3.3 days.

When split by specialty the average length of stay for all three of the most common specialties (based on count of elective activity) at the hospital was similar to the England average.

**Elective Average Length of Stay - Pilgrim Hospital**

![Graph showing average length of stay for elective patients at different specialties.]

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

**Pilgrim Hospital - non-elective patients**

The average length of stay for all non-elective patients at Pilgrim Hospital was 5.5 days, which was similar to the England average of 5.0 days.

When split by specialty the average length of stay for two of the three most common specialties (based on count of non-elective activity) at the hospital was similar to the England average. These were General Surgery and Urology. The average length of stay for non-elective Trauma and Orthopaedics patients was 7.5 days which was lower than the England average of 8.9 days.
Non-Elective Average Length of Stay - Pilgrim Hospital

![Graph showing average length of stay for different specialties]

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

Meeting people’s individual needs

At pre assessment, information packs were given to patients that included information on venous thromboembolism, anaesthetic, MRSA and fasting instructions. Patients we spoke with on the surgical wards told us they were given useful information regarding their treatment, what was available and what to expect. Packs also contained telephone numbers for further advice.

There were numerous assessment processes in place that supported meeting people’s individual needs. There was good evidence of risk assessments and acting on identified risks. This included the identification of sepsis for which staff had received training.

Staff on the day case unit worked closely with the pre assessment clinic staff in order to identify and care for patients living with a learning disability or dementia. Staff used pictorial risk assessments and care plans.

There were no mixed sex breaches as bays were adjusted to meet the demand for male and female patients.

The service had out of hours emergency arrangements with the mental health team which was known by all staff we spoke with. There was also 24/7 access to the advanced mental nurse practitioners and psychiatrist.

There was an enhanced care risk tool which aided the delivery of care to patients in need of additional support for those patients at higher risk of falls or dementia. The tool assessed and graded patients as either red (high risk), amber (some supervision: needing 15 minute checks) and green (low risk) needing less observations.

Patients with a diagnosed learning disability had this recorded within the electronic patient record along with their admitting diagnosis. There were two learning disability nurses for the trust.

The trust had relaunched of safeguarding champions on the wards, one or two for each ward. Staff received four sessions per month. This month’s focus was homelessness and boards were being created on the wards to inform patients about their work.

On all wards we visited a bell was rung at meal times which brought staff to assist with feeding patients. We saw no red trays, jugs lids or beakers. We saw staff helping patients have their lunch and one volunteer assisting with feeding.

Single sex bays were used across all wards and day surgery care.
Access and flow

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

From November 2016 to October 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was 56.2% compared to the England average of 69.9%. The trust performed consistently below the England average for Surgery in every month reported.

In October 2017 and November 2017 the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.

Between December 2017 and March 2018 data provided by the trust showed there was one patient transferred from ICU to a surgical ward during the night.

Referral to treatment rates (percentage within 18 weeks) for admitted pathways, United Lincolnshire Hospitals NHS Trust

(Source: NHS England)

The trust had introduced a new way of working called Red to Green to reduce delays across the hospital and improve patient flow.

A red day was when a patient waits for more than 14 hours for an intervention, such as a diagnostic test, therapy or senior clinical review. If these delays were avoided then it was classed as a green day.

The trusts referral to treatment time (RTT) for surgical services continued to be lower than the England overall performance; for January 2018 the RTT was 59%. 18 week waits for general surgery (78%), breast surgery (97%), Colo-rectal surgery (86%), vascular (81%) and Trauma and orthopaedic (79%).

The trust provided data for cancer waiting times which showed for quarter three 2017/18 the 14 day wait was worse than the national rate 91.2% (England 93%) and 62 day wait 70.9% (England 85%). However the 31 day wait was better than the England rate 96.8% (England 96%).

The trust provided data (November 2017- January 2018) which showed the Pilgrim hospital had 66 delayed discharges, amounting to 1,963 lost bed days. The trust had a full capacity protocol.
dated 2017 which the service used when bed capacity was at a premium. Staff we spoke with were aware of the protocol and knew how to manage when beds were short.

Data was also provided which showed between November 2017 and January 2018 there were 64 (5%) patients who experienced a delay in transfer of their care which did not meet the trusts target of 3.5%.

MDTs took place daily to discuss patient flow and review all admissions and discharges.

Staff in the pre assessment team would be part of the enhanced recovery pathway for patients having a knee or hip replacement in order to reduce the length of stay for this type of surgery. There were weekly classes which included physiotherapists, occupational therapists, medical and nursing staff.

Patients coming into the hospital for elective surgery would arrive at the Surgical Admissions Unit (SAU) and either go to the main theatres for elective surgery or go to the day surgery unit. Those patients having major surgery would then be admitted to one of the surgical wards and those having day surgery would be discharged from the day surgery unit. So for those patients having major surgery they would return to a ward where they would not have met their surgical team.

The service had a Standard Operating Procedure (2017) escalation plan for using the ground floor recovery area for additional bed space when needed. The escalation plan included a risk assessment, implementation plan and monitoring mechanisms to ensure patients were safe whilst staying within the recovery area. Data provided by the trust showed that between January 2017 and December 2017, 351 patients waiting to be admitted to a ward were kept in recovery due to a lack of beds on the wards.

We visited ward 3B which was the trauma and orthopaedic ward. There were 29 beds with one bay designated as the trauma assessment unit. This trauma and assessment unit was manned by three trauma co-ordinators who would take patients directly from the emergency department. These patients would be cared for whilst awaiting blood results or an orthopaedic review and further management. Patients with simple fractures would be managed on this unit and discharged home to await further surgery when needed. Staff would keep in touch with these patients and liaise with them, the doctors and operating theatres.

We saw staff from the re-enablement team visit the wards in order to expedite patients discharge. This support timely discharge from the service.

The Bostonian ward was used for elective surgery as ward 5B was used for medical outliers. This ensured that elective patients were still been operated upon even though there was one ward closed for elective surgery.

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

A breakdown of referral to treatment (RTT) rates for admitted pathways in surgery, broken down by specialty is below. All six specialties at the trust performed below the England average for admitted RTT rates. The 0% RTT rate in cardiothoracic surgery relates to only one patient.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.7%</td>
<td>77.0%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>61.1%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>57.5%</td>
<td>61.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>47.3%</td>
<td>72.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>45.2%</td>
<td>64.4%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0.0%</td>
<td>83.1%</td>
</tr>
</tbody>
</table>
Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

**Percentage of patients whose operation was cancelled and were not treated within 28 days - United Lincolnshire Hospitals NHS Trust**

Over the two years, the percentage of cancelled operations at the trust showed a declining trend and since quarter 3 of 2016/17 the trust's performance has been similar to the England average.

In the most recently reported quarter (Q2 2017/18) 3.8% of the 679 cancelled operations were not treated within 28 days which was lower than the England average of 6.8%.

**Cancelled Operations as a percentage of elective admissions - United Lincolnshire Hospitals NHS Trust**

Over the two years, the percentage of cancelled operations at the trust showed an upward trend, and was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

*Source: NHS England*

Data provided by the trust for December 2017 showed there were 51 (2.9%) patients cancelled on the day of operation and 11 (0.63%) on the day before their operation.

Between December 2017 and February 2018 data provided by the trust showed operating theatres lost 246 operating sessions with an operating theatre utilisation rate of 65%.

The surgical unit held weekly meetings to review theatre start times and improve theatre utilisation. This was attended by a consultant anaesthetist, theatre scheduling team, theatre sister,
anaesthetic secretary and business staff. All cases were reviewed, equipment agreed for each operation and timings of operations taken into account.

We saw good working relationships where the team were trying to schedule as many operations as possible whilst maintaining a balance of safety with the appropriate number of staff who could cover.

Ward staff appeared to have a good awareness of maintaining patient flow and facilitating discharges. Daily MDT meetings took place to identify and troubleshoot actual and potential discharge delays, with the involvement of social care staff on some ward rounds to expedite packages of care.

Learning from complaints and concerns

Summary of complaints

From October 2016 to September 2017 there were 188 complaints about surgical care. The trust took an average of 69 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 188 complaints, 130 had been closed at the time the data was provided and only 7.7% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days. Even when taking this target into consideration still only 20.0% of all of the closed complaints were closed within 50 days.

At Pilgrim Hospital there were 83 complaints. The trust took an average of 75 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 83 complaints, 54 had been closed at the time the data was provided and only 9.3% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days. Even when taking this target into consideration still only 24.1% of all of the closed complaints were closed within 50 days.

There were 13 complaints that were re-opened in the time period.

The most common themes in complaints at Pilgrim Hospital were: injury sustained during treatment or procedure (12), communication with the patient or their family/carers (nine), discharges including discharge arrangements and inappropriate discharges (eight), delay or failure to diagnose (seven) and the attitude of staff (five).

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

Patients we spoke with knew how to make a complaint. However there were no ‘How to Complain’ posters seen at the entrance to the wards.

Staff told us they would try and manage a patient complaint informally and act as soon as possible in order to address patients’ complaints. We saw and were told of examples of learning from complaints.

Is the service well-led?

Leadership

The surgical business unit was sub divided into five directorates which included surgery, orthopaedics, head and neck, theatres, anaesthetics, critical care, pain and the Bostonian ward (a private and NHS ward). Four of the directorates were led by a clinical director, general manager, head of nursing and matron. The Bostonian ward was led by a general manager.
We were told this structure was to be reviewed as the lines of accountability were not as clear as they could be. For example the matron for the theatre, anaesthetics, critical care and pain directorate also covered surgery even though it was not part of her directorate.

The senior teams were experienced and had been in post for a number of years. They were clear about the challenges the services experiencing and were working with other senior teams in reviewing the longer term plans for the hospital site.

Nursing staff told us their senior managers had a ‘fix it’ attitude. However one junior medical doctor told us ‘consultants need to exert more leadership and discipline’, ‘there is a disorganised and unprofessional manner amongst some surgeons’.

Senior sisters would attend a three monthly meeting called ‘confirm and challenge’ where human resources, finance staff and the head of nursing would attend to discuss individual ward activity. Ward staff told us they were ‘held to account’ and had to provide answers to questions around staffing, levels, finance and safety issues. This made some staff feel intimidated and uncomfortable.

**Vision and strategy**

The trust had long term strategy called ‘Our Ambitions 2021’. Staff told us these had recently been displayed around the trust. Although staff were generally unaware of trust or local strategies, all were very aware of maintaining patient flows and had a very good focus on patient discharges.

There was also a ULHT clinical services strategy 2017-2022 dated February 2018. This set out the trusts vision for clinical services for the next five years. The strategy had been developed with other external partners and the process of commencing more in-depth discussions with the trusts commissioning groups were due to begin. Staff we spoke with had not been part of developing their strategy.

Senior staff told us there were discussions around the review of clinical services across the trust. Whilst there was no agreement as to which direction the trust was going to take, staff were unsettled as there were ‘rumours’ about closing/moving services.

The surgical admissions unit (SAU) was used for the admission of patients for surgical day case and elective surgery.

**Culture**

There was a culture of openness and staff felt comfortable in reporting incidents and poor practice. Staff had access to appraisals and development although due to the lack of nursing staff training was not always accessed in a timely manner.

Staff on the wards and departments told us they worked well in their teams and helped one another when necessary.

A number of nursing staff told us they were often moved to other wards. Some staff told us this was their biggest problem and they were worried when coming to work as they knew they would be moved to a ward which they knew nothing about. Data provided by the trust showed in January 2018 on ten occasions members of staff were moved from the operating theatres to wards or the emergency department.

Staff told us they understood why they had to be moved but often had to complete their own work as well which resulted in being late off duty.
Junior doctors we spoke with described good relationships and support from registrars, consultants and nursing staff.

Staff within the operating theatres felt their morale was low due to the removal of overtime payments and removal of tea and coffee supplies.

Staff remained proud to work at the trust and they told us they felt team working was very positive and they supported one another.

Staff told us they had little opportunities to develop themselves as the shortage of staff and finances had resulted in external training being cut.

Staff felt well supported by the trust occupational health service, counselling services and employee assistance arrangements.

**Governance**

Each of the directorates had monthly governance meetings where incidents, risks, complaints and staffing were discussed. For example the anaesthetic clinical governance meeting February 2018 showed the number and types of incidents that had occurred which included the description of the incident and the actions taken to ensure the incident wouldn't happen again.

Senior ward staff would attend these meetings and feed back to their ward staff.

Surgical staff conducted quarterly theatre governance audits. The theatres undertook a weekly audit of the WHO checklist with different specialities such as urology, trauma and orthopaedics and general surgery, with over 95% compliance for WHO completion.

There was a regular orthopaedic meeting which discussed governance issues such as clinical problems, mortality and morbidity, performance and progress. Plans to attract a ‘Best Practice Tariff’ were launched and supported by this group.

Progress with National Safety Standards for Invasive Procedures (NATSSIPs), were reported on in the monthly performance report, which was reported into divisional quality and safety meetings and into the trust wide quality governance steering group.

The trust had two full time sepsis practitioners with the overall role of providing clinical leadership, raising awareness, ensuring early recognition and intervention and promoting the use of sepsis screening and management tools.

Mortality and morbidity discussions would take place twice weekly and any learning from these meetings would be shared with the surgical division.

However there were a number of governance and safety processes in place such as ward rounds, board rounds, the golden hour, clinical cabinets and safety quality matrixes that made staff feel over managed. One senior member of staff told us they felt governance and safety had become repetitive and was going to be reviewed to make the process more streamlined.

We saw and staff told us there was a systematic programme of clinical audit to monitor the quality, operational and financial processes. Financial management was discussed at monthly governance meetings.

**Management of risk, issues and performance**

The service used a quality scorecard to assess performance and risk on a monthly basis against trust standards or targets. This was then reported in monthly divisional performance review reports.
and included information on staffing levels, infection screening and infection rates, rates of harm free care, pressure ulcers, falls, dementia screening, and hand hygiene compliance.

There were 18 risks on the surgical risk register; one breast surgery, three general surgery, four ophthalmic, three orthopaedic, three urology, two anaesthetics and two vascular.

The majority of risks on the risk register continued to be related to the lack of medical equipment, storage space and staffing levels.

Risks were not always dealt with in a timely manner currently there were 10 risks past their review date and the emergency call bells remained on the risk register since 2014. This was highlighted in the April 2017 CQC report.

Matrons and other managers conducted daily ‘golden hour’ visits in clinical areas at different times of the day and night to monitor the environment and see what could be improved. We saw these had been completed every week. Examples of issues they had identified included storage of records and non-compliance with the bare below the elbow policy. We saw these issues were fed back to staff at the time who had acted upon them.

**Information management**

The trust used a paper system to collate patient treatment and care on the wards.

Operating theatres used an electronic theatre management system which tracked patient’s details throughout the patient’s journey through the department. This system was also used to gather and analyse performance information relating to start and finish times and theatre utilisation data.

There were sufficient amounts of computer terminals to enable staff in accessing the intranet, worldwide web, and internet.

All surgical divisions had dashboards to enable senior staff in monitoring divisional key performance indicators.

Staff told us the introduction of an electronic early warning system for patients at risk of deterioration had made a significant difference.

**Engagement**

On surgical wards, positive comments from friends and family results were on display, as were plans to address negative comments

Ward team meetings took place monthly where staff were updated about information relating to their specialty. We were told these did not always take place as the staff were too busy to attend.

We were given no evidence to show staff and the public were involved in shaping the direction of the trust or surgical services above and beyond friends and family test.

We were told there was a possibility of the SAU moving next to the emergency department and becoming a surgical assessment unit. Again there was no agreement about this and staff told us this was unsettling.

**Learning, continuous improvement and innovation**

Pilgrim hospital housed a clinical research centre. Staff within the surgical unit participated in clinical research which demonstrated openness and confidence to share data for the improvement of patient care.

Staff from the colorectal and stoma care department at Boston’s Pilgrim Hospital received a prestigious award for the way they support unpaid carers.
United Lincolnshire Hospitals NHS Trust provides care for children and young people at Lincoln County Hospital and Pilgrim Hospital Boston. Lincoln County Hospital and Pilgrim provide paediatric services for children from 0 to 16 years of age including day case and emergency services.

(Source: Routine Trust Provider Information Request (RPIR) – Context acute tab)

The Trust had 77 Children’s & Young Peoples (C&YP) inpatient beds across two sites. This included the acute children’s wards, the children’s assessment unit on 1 site, the neonatal unit, the special care baby unit and transitional care clinical areas.

- Lincoln County Hospital: 46 beds/cots located within 4 clinical areas
- Boston Hospital, Boston: 31 beds/cots located within 2 clinical areas

At the time of the inspection, a decision had been made to reduce the overall number of paediatric inpatient beds at Pilgrim hospital to eight. Shortly prior to the inspection, there had already been a reduction of beds from 19 to 12 due to concerns regarding staffing levels on the children’s ward.

There were eight special care baby cots and four transitional care cots at the time of the inspection.

(Source: Routine Trust Provider Information Request (RPIR) – Sites Acute tab)

The trust had 6,228 spells from October 2016 to September 2017.

Emergency spells accounted for 97% (6030 spells), 2% (121 spells) were day case spells, and the remaining 1% (77 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from October 2016 to September 2017, United Lincolnshire Hospitals NHS Trust.

Total number of children’s spells by Site, United Lincolnshire Hospitals NHS Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>3,594</td>
</tr>
</tbody>
</table>
Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 90 to 100% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical/dental and nursing/midwifery staff in children’s services care is shown below:

Pilgrim Hospital Boston – medical/dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>18</td>
<td>20</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>17</td>
<td>20</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>17</td>
<td>20</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>16</td>
<td>20</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>15</td>
<td>20</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>9</td>
<td>20</td>
<td>45%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

There were 11 training courses eligible for medical and dental staff for children services of which the hospital met the target for four modules. There are also two modules where medical and dental staff are not eligible but have completed. The lowest completion rate for children services across this hospital was 45% for major incident awareness training of which nine medical and dental staff were trained of the 20 eligible for the module.

Last year the medical and dental staff for children and young people did not meet the training completion rate, reaching 85% for the financial year April 2016 to March 2017.

Pilgrim Hospital Boston - Qualified nursing & health visiting staff (Qualified nurses)

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

(Source: Hospital Episode statistics)
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>18</td>
<td>20</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>17</td>
<td>20</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>17</td>
<td>20</td>
<td>85%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>16</td>
<td>20</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>16</td>
<td>20</td>
<td>80%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3 Additional)</td>
<td>9</td>
<td>16</td>
<td>56%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff for children services were eligible to complete all of the six safeguarding training modules set out by the trust. They did not meet the 90% target for five modules.

Pilgrim Hospital - Qualified nursing & health visiting staff (Qualified nurses)
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>47</td>
<td>48</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>47</td>
<td>48</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>46</td>
<td>48</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>46</td>
<td>48</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>45</td>
<td>48</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3 Additional)</td>
<td>15</td>
<td>18</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

There were six safeguarding modules eligible for qualified nursing staff within the children services of which the trust target was met for five modules. The lowest completion rate was for safeguarding children (level 3 additional) which was completed by 15 staff but eligible for 18.

- Pilgrim Hospital Boston had a 94% safeguarding training completion rate for all staff.

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

Staff were knowledgeable about safeguarding issues. Staff could describe the types of abuse children and vulnerable people could experience and were able to describe the incident and reporting process. This included child sexual exploitation and female genital mutilation.

There was an alert process in place which flagged children and young people known to have safeguarding concerns.

There was a child safeguarding lead responsible for co-ordinating communication for children at risk of safeguarding issues and as a resource for staff.

**Cleanliness, infection control and hygiene**

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.90 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

All areas of the clinical setting were visibly clean. Domestic staff routinely applied “I am clean” stickers to beds and furniture for example once they had cleaned those items. We observed side-rooms being cleaned with appropriate surface cleaners following the discharge of patients. Three parents we spoke with confirmed their side rooms had been cleaned daily whilst they had been inpatients on the ward.

There was a process in place for ensuring staff physically examined the internal layers of mattresses to ensure they had not been soiled or contaminated following the failure of the outer waterproof layer. We observed this process being carried out during the inspection.

During our observations of patient care staff demonstrated good adherence to hand hygiene practices, including washing their hands and using antibacterial hand gel at appropriate intervals.
We also saw appropriate use of personal protective equipment (PPE) such as disposable gloves and aprons, which were readily available in the clinical areas. Members of staff were also observed coming out of the unit to greet visitors and to ensure people decontaminated their hands before entering the special care unit.

Staff adhered to trust uniform policy and observed bare below the elbow practice. This minimised the risk of infection.

We reviewed cleaning schedules and audits. Housekeeping and domestic teams used cleaning schedules specific for each clinical and non-clinical area and checklists were in place to indicate when these had been completed. This included daily water flushing checks. We found they had been appropriately completed by staff.

**Environment and equipment**

Swipe access was required to gain entry to both the special care baby unit and the children’s ward. However, on a number of occasions, members of the inspection team were able to gain entry to the children’s ward without being challenged by staff members. Access to the special care unit was better managed, with staff challenging visitors.

At our last inspection in 2017, we raised concerns regarding the lack of ligature risk assessments on the children’s ward. This was despite the ward admitting children and young people with mental health problems including social ideation and self-harm. At this inspection, we found staff had completed an environmental ligature risk assessment to mitigate against the risk of patients causing self-harm by way of ligature points. Whilst the risk assessment included each room on the children’s ward, not all risks had been identified. For example, during the inspection, the inspection team were accommodated in an interview room that was unlocked. We noted a large metal television trolley was stored in the room; the trolley held a television which had flexible cables hanging from it, as well as a metal bar being attached to the trolley; this was an obvious ligature point that could be easily accessed. We did note that two pairs of ligature cutters had been placed on the resuscitation trolley and signs had been placed around the ward, highlighting their location. Ward staff were able to describe the risk assessments they completed for each patient who was admitted to the ward with a diagnosis of mental health problems. Mitigation included ensuring patients at risk were supervised at all times. Following our inspection information from the trust confirmed that the ligature risk identified above had been removed.

The resuscitation trolley on the children’s ward was checked daily. A review of documentation during the inspection confirmed this. The paediatric safety quality dashboard also confirmed 100% compliance with daily checks for the preceding six months.

There were effective arrangements for managing waste and clinical specimens, this included classification, segregation, storage, labelling, handling and, treatment and disposal of waste. We saw staff adhering to this during our inspection.

We found equipment in use conformed to the relevant safety standards and had been regularly serviced in accordance with manufacture guidance. Electrical equipment was PAT tested.

**Assessing and responding to patient risk**

**CQC Children and Young People’s Survey 2016**

In the CQC Children and Young People’s Survey 2016 the trust scored 7.83 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their
medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.52 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

CQC Children and Young People’s Survey 2016 questions, safe domain, United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.90</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.83</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.52</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

During our previous inspection of this service in 2017, we found the level of understanding of sepsis amongst staff to be poor. Staff were not routinely completing sepsis assessment charts to aid in the early recognition of the septic child. In response, the service had launched a sepsis task and finish group which was chaired by a deputy matron. The task and finish group oversaw the implementation of the sepsis-six pathway and staff compliance with treatment policies, staff training and awareness of sepsis across children’s services.

A review of five sets of patients notes during the inspection confirmed staff were utilising the sepsis-six screening tool as well as applying the management protocols in cases where children had been identified as being at risk of developing sepsis. The paediatric quality safety dashboard also confirmed compliance with the sepsis care bundle for the preceding three months.

The service functioned as a level one Paediatric Oncology Shared Care Unit and ensured children currently receiving oncology treatments who presented with signs of sepsis or febrile neutropenia were commenced on antibiotics in line with local and national policies; this included the administration of antibiotics within one hour of arrival.

Staff utilised a range of risk assessments to support the delivery of care to children and young people. Staff were able to describe the various risk assessments used including paediatric early warning scores and escalation protocols for the deteriorating child; skin integrity assessments, nutritional assessments and management of vulnerable children. A review of five sets of notes during the inspection confirmed that staff were completing appropriate assessments of children.

Paediatric early warning observation charts which were age specific were routinely being used and there was evidence of appropriate calculation of observational scores and escalation where appropriate. There was persistently good compliance with the use of paediatric early warning tools; in the preceding twelve months, staff had selected the correct age-appropriate observation chart in nine of the twelve months audited. For three months, compliance had dropped to 87.5%; the selection of an incorrect early warning chart could impact on the appropriate recognition of a deteriorating child due to physiological parameters for children being age specific. It was noted
however that staff consistently totalled the correct score for children in 100% of cases during the preceding twelve months. All children had their blood pressure recorded on admission and the frequency with which observations should be taken was routinely recorded. The paediatric quality safety dashboard confirmed appropriate escalation took place where necessary during the previous twelve months which further supported the good compliance with the use of early warning tools.

Compliance with visual infusion phlebitis risk assessments was poor. The children’s ward scored 100% with completed VIP charts in two of the previous twelve months. In five months, there was 0% compliance of a VIP chart being completed (March, April May, July and August 2017), 25% compliance in November 2017, 60% compliance in June 2017, 66% in February 2018 and 75% in October 2017. Compliance with ensuring peripheral cannulas being labelled correctly was also poor with 100% compliance only being achieved in February 2018 and March 2018. For the remainder of the year compliance ranged from 0% (March, April May and October 2017) to 75% in November 2017.

Following immediate concerns with regards to the numbers of nurses competent to care for children in the ED at Pilgrim Hospital the trust had made a decision to move nurses from the children’s ward to the ED. This resulted in the children’s nursing team determining that, to meet Royal College of Nursing recommended safe staffing standards, there would need to be a reduction of inpatient beds from 19 to 8 beds. This generated further significant risks within the emergency care pathway for children at Pilgrim Hospital. There had been no capacity and demand modelling undertaken to offer assurance to the board that eight beds would be sufficient to meet the needs of the population. Furthermore, medical staff reported the challenges of having to either transfer patients or clinically prioritise patients for admission, thus increasing the need for patients to return as “ward attenders” as a means of trying to manage risk.

There had been a reduction of inpatient beds which required the trust to cancel all elective paediatric surgery at Pilgrim Hospital. We were not assured that a sufficiently robust clinical risk assessment had been undertaken to ensure that children waiting surgery have been clinically triaged and prioritised. We were not assured that there was sufficient mitigation in place to meet the needs of those children requiring elective surgical procedures. This lack of risk assessment was further compounded by the fact the hospital did not have a formalised children’s surgery committee as recommended within the Royal College of Surgeons Standards for Children’s Surgery (2013).

Senior staff within the service considered the arrangements at the time of our inspection had increased the overall risk to the safety and welfare of children attending Pilgrim Hospital. A lack of robust planning had generated further, predictable risks within the emergency care pathway.

**Nurse staffing**

The trust has reported their registered staffing numbers below as at March 2018. There were 184.7 less nursing staff in place within the children’s core service than was planned to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>Budgeted WTE Registered Nurses</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim Ward 4a</td>
<td>28.65wte</td>
<td>18.6wte</td>
</tr>
</tbody>
</table>

(Source:DR140)

**Vacancy rates**
There was an escalation of concerns regarding the number of paediatric nurses available to support the children's ward to the private section of the trust board in August 2017. A further presentation of the concerns was provided to the private section of the trust board in September 2017. It was reported the total number of children’s nurses available to support the service was 16.5 whole time equivalent children’s nurses (as at September 2017) and that this was not sustainable, with further reductions in total headcount expected by November 2017. Whilst it was acknowledged the trust was able to continue to maintain the establishment in order two children’s nurses were scheduled for each shift, it was recognised there was no long-term solution. The long-term mitigation was to await the outcome of decisions being made within the sustainability and transformation plan (STP) which was considering and evaluating the most appropriate model of care for children’s services for the future. The Director of Nursing reported that all other local trusts had been asked for support with staffing but none had been able to help. There was recognition that recruitment of children’s nurses, long term, posed a significant risk to the organisation.

As of January 2018, the hospital reported a vacancy rate of 35% within the children’s ward nursing establishment. A further analysis of the nursing establishment by the nursing management team revealed that when taking in to consideration long term absence such as sick leave, parental leave or supernumerary status, the real time vacancy rate was 49%.

The prediction was that by end March 2018, 15.1wte nurses would be in post due to a further resignation. This was part, mitigated by the reliance on one agency nurse who had been block booked to cover the equivalent of 1.46wte staff until the end of April 2018. The management team acknowledged this was not a long-term solution.

(Source: Staffing Report January 2018)

The management team acknowledged the significant challenges they faced in regards to recruiting qualified children’s nurses to the service. They had adopted a range of tactics to try and recruit to the service including financially supporting adult nurses to undertake their conversion training in order they could become registered children’s nurses.

Staffing risk assessments took place on a daily basis to ensure there were sufficient numbers of nursing staff to meet the acuity needs of children on the ward. In addition, the nursing management team had linked with the local university to organise an honorary contract with a lead lecturer in children’s nurses in order the post holder could work alongside nurses on the ward to help build a more qualified and competent workforce.

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 6% in children’s services; compared to the trust target of 7% and no staff group more than 20% above the target.

- Pilgrim Hospital Boston: 6%

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

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 7% in children’s services; compared to a trust target of 4.5%.

- Pilgrim Hospital Boston: 8%
Bank and agency staff usage

The staffing analysis for the children’s ward for January 2018 revealed 14.8% of shifts were covered by bank staff; 7.8% of shifts covered by agency staff and 16.2% of shifts remained unfilled. During the month of December 2017, the lowest fill rate for registered nursing staff during the day was 47% on 15 December, with the best fill rate for days being 89% on 3, 30 and 31 December. With the exception of one night (18 December) all night shifts were covered with 100% registered nursing staff.

The average skill mix for the ward was approximately 58% registered versus 42% unregistered staff; the local nursing management team considered this skill mix to be below what was required on the ward, when considering acuity and needs of patients. The reported ideal skill mix was 70% registered, supported by 30% non-registered health professionals.

As a result of the challenges faced by trying to staff the children’s ward, a decision had been made to reduce the total number of beds from 19 to 12; we understand this reduction in beds took place approximately two days prior to CQC undertaking their first unannounced inspection of the hospital. A further reduction in beds to eight, occurred following concerns raised by CQC regarding the children’s emergency care pathway which had resulted in three additional members of paediatric nursing staff being re-deployed to support the emergency department.

During the inspection, we were informed of a serious incident that had occurred in 2017. A patient who was also a patient of a local mental health service, had been admitted to the ward and required one-to-one supervision. Senior nursing staff informed us the patient was receiving one-to-one care from health professionals who worked at the mental health service. We queried whether the trust had undertaken any checks of those health professionals to ensure the trust was meeting the requirements of Regulation 19, Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Regulation 19 requires registered health providers to carry out appropriate checks on perspective and current staff to ensure they are suitably fit and proper to carry out their role. This includes checks to determine whether individuals have been placed on a barred list, and so are prevented from working with children or vulnerable adults; character references, identification and employment history. The trust responded by stating, “The [patient] was admitted from [another service] which is a residential mental health setting and as such employment checks are the responsibility of [that provider] as identified in their Safeguarding and Child Protection policy”. This is contrary to the requirements of Regulation 19 which makes no provision for permitting registered providers from discharging their legal requirements to comply with the regulations by permitting other registered providers from undertaking checks on their behalf. The trust acknowledged they would review their systems and processes in relation to the governance of potential carers providing direct supervisory and/or clinical care within the acute hospital.

Staffing within the special care baby unit was noted to be in line with national standards.

Medical staffing

There were 3.9 less medical staff in place within the children’s core service then was planned to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilgrim</td>
<td>6.0</td>
<td>5.5</td>
</tr>
</tbody>
</table>
The service remained non-compliant with the Royal College of Paediatrics and Child Health “Facing the Future” staffing standards.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 2% in children’s services; against a target of 12% for medical staff

- Pilgrim Hospital Boston: 5%

(Source: Routine Provider Information Request (RPIR) – Total staffing)

**Turnover rates**

From November 2016 to October 2017, the trust reported a turnover rate of 3.4% in children’s services; compared to the trust target of 7% and no staff group more than 20% above the target.

- Lincoln County Hospital: 0%
- Pilgrim Hospital Boston: 8%

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

**Sickness rates**

From November 2016 to October 2017, the trust reported a sickness rate of 3% in children’s services; compared to a trust target of 4.5%.

- Lincoln County Hospital: 1%
- Pilgrim Hospital Boston: 5%

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

**Bank and locum staff usage**

At the time of inspection, children’s services was supported by 5.5 wte consultants, two of which were working on a locum basis.

Senior clinical leaders reported recruitment to consultant posts had been challenging, in part because of the location of the hospital. Despite repeated recruitment campaigns, there had been low numbers of applicants to advertised posts. The medical leadership team had commenced overseas recruitment to try to provide a long-term solution to the problem. We noted that consultant on-call rotas continued to be covered by the existing consultant body. It was considered by the leadership team that whilst staffing of consultants proved a challenge, the good will of the existing consultant body ensured a safe service could be provided in the short to medium term. Concerns were voiced however that such reliance on goodwill was impacting on morale amongst the workforce, with some staff raising concerns over the long-term resilience of consultants to support the rota. It was further considered that whilst consultants were able to provide an appropriate clinical service, the impact was that activity such as clinical audit and research was likely to be impacted in the longer term.

**Staffing skill mix**

In October 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same.
Staffing skill mix for the 58 whole time equivalent staff working in children’s services at United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>26%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>30%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

Records

We reviewed five sets of medical notes during the inspection. In two instances, we found notes to be poorly filed; loose pieces of paper had been placed in to casefiles but had not been secured, increasing the risk of them being lost or misplaced.

Patient records we kept in two places; medical notes were stored in an unlocked notes trolley located next to the nurses station. A second set of notes containing nursing documentation such as observation charts and risk assessments were kept by the patient’s bed or stored in file holders outside side rooms.

There had been an improvement since our last inspection in regards to staff recording their designation and for signing entries. A review of each of the entries made within each of the five sets of notes were all signed, and in the majority of cases, staff had recorded their designation.

Medicines

Medicines were stored appropriately. Staff routinely recorded the temperature of fridges in which medicines were stored.

Prescription charts were completed to an acceptable standard. Medical staff wrote clearly, using appropriate names for medicines and where appropriate, writing out the unit of measure for small doses.

There was evidence of good anti-microbial stewardship. During ward rounds, staff paid sufficient time and detail to the use of antibiotics by discontinuing where appropriate.
Staff responded promptly when we noted the magnetic lock on the clean utility room had moved position, therefore allowing easy access to the room for a short period of time during the first day of inspection.

Controlled drugs were stored appropriately. A review of the controlled drug register demonstrated an acceptable standard of documentary recording of the supply, administration and destruction of controlled drugs.

**Incidents**

**Never Events**

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

From January 2017 to December 2017, the trust reported no incidents classified as never events for children’s’ services.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with one (25% of total incidents).
- Apparent/actual/suspected self-inflicted harm meeting SI criteria with one (25% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with one (25% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (25% of total incidents).

*(Source: Strategic Executive Information System (STEIS))*

There had been significant delays in the investigation of serious incidents that had happened in previous years. This was in part due to the poor quality of investigations leading to reports being rejected or deferred for either re-investigation or review by other health professionals to ensure all lessons learnt and contributing factors had been explored. We noted the incident investigation...
Evidence appendix United Lincolnshire Hospitals NHS Trust

report for one serious incident received internal approval on 3 October 2017, some 235 days after the incident occurred. National guidance, as set out in the National Serious Incident Framework (2015) which stipulates serious incident investigations should be completed and signed-off by the Clinical Commissioning Group within 60 days of being reported. Whilst the investigation was detailed and explored a range of contributing factors, the delay in completion of the investigation report had led to delays in actions being implemented in a timely way. Examples included simulation training as only having commenced in January 2018, some thirteen months after the initial incident. The management team acknowledged the need to improve the timescale for investigating incidents and subsequent dissemination and embedding of lessons learnt to ensure the risk of future similar incidents occurring could be reduced or mitigated.

(Source: DR134, DR136, NM003)

Learning from serious incidents had not always been implemented robustly or systematically. For example, an action from a serious incident, which occurred in 2014, was that nursing staff would attend medical handovers that occurred on the ward at 09:00 each morning. The rationale was to allow for a thorough multi-disciplinary discussion of all patients who were receiving in-patient care. We attended and observed the medical handover on 15 March 2018. The on-call Paediatric Consultant, junior doctors and the nurse-in-charge for the paediatric in-patient ward attended the handover.

(Source: DR136, DC002)

Further examples of where actions resulting from serious incidents had not been fully implemented included the failure to develop robust emergency escalation pathways at Pilgrim Hospital. The investigation of a child death in 2014 identified that appropriate conversations had not taken place between the accident and emergency department and the paediatric team as to the most appropriate clinical area to which the child should have been admitted. A detailed investigation into the death of a second child at Pilgrim Hospital in December 2016 again recognised an acutely sick child had been referred directly to the children’s ward and not to the emergency department at Pilgrim Hospital. Consequently, the paediatric on-call consultant nor registrar had been informed of the pending admission and therefore were not initially present to assess the child in a timely way. It was noted from the investigation into the 2016 death that a review of the emergency care pathway was required to mitigate against future similar cases occurring again. A similar action had arisen following the serious incident in 2014.

There was also an action for the trust to produce a standard operating procedure which set out robust criteria for the acceptance of children directly to the children’s ward at Pilgrim Hospital. The completion date for this standard operating procedure to be completed was December 2017; we were not provided with a formalised standard operating procedure at the time of inspection in March 2018 and was advised the procedure remained at the draft stage.

(Source: DR134, DR136)

Following the inspection, the trust provided CQC with four draft emergency pathway documents dated 22 March 2018. The trust advised us the pathways were currently subject to discussion and consideration in line with local trust governance processes.

(Source: JS-CJ Corres 22 March 2018, Appendix 4)

We asked the trust to provide us with a breakdown of all incidents reported within children’s services and neonatology for the previous twelve months. There were 193 incidents reported within neonatal services at Pilgrim hospital between April 2017 and March 2018. Of these, 14 were classified as near miss incidents, 175 were classified as no harm. Three were classified as low harm (one incident related to a staff member and not a patient); one as moderate harm (but was
linked to a member of staff collapsing on the special care unit) and zero as significant harm or death.

Staff could describe examples of where actions had been taken because of incidents being reported. This included the relocation of the resuscitation trolley from a side room to a visible area in the corridor, near to the nurse’s station. Staff understood the importance of bringing equipment to a sick child, instead of moving the child to a room which had previously been labelled as the high dependency room.

We received a mixed response from staff as to whether they received feedback from individual incidents they had reported. Some staff said feedback was consistent and timely whilst others said they had not received feedback to incidents they had reported.

There was no formalised mechanism for instigating paediatric morbidity and mortality reviews across children’s services. This was despite there being recognition of the importance of mortality reviews within a serious incident investigation report from relating to an incident in 2014. The report said, “It was accepted practice that mortality reviews should be carried out on all child deaths and any lessons learnt should be discussed at clinical governance however, there was no robust assurance process when this incident occurred”. Interviews with members of the senior clinical team during the inspection confirmed that whilst there was a process for considering perinatal morbidity and mortality, there remained no formal process for consideration of paediatric morbidity and mortality.

There was some oversight of those incidents affecting children who visited other clinical areas within the hospital, for example those attending the emergency department. However, this process was informal with only senior members of the children’s team being alerted through email when an incident was logged on the system. Investigation for incidents within other clinical departments was managed by those responsible for that clinical setting with little engagement from the children's team.

(Source: DR136)

Regulation 20 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014 is a regulation introduced in November 2014. This duty of candour regulation requires the organisation to notify relevant persons (often a patient or close relative) that an incident has occurred, to provide reasonable support to the relevant person in relation to the incident and to offer an apology.

We saw that there was a process in place for ensuring that where relevant incidents may potentially occur, the regulatory requirement to ensure regulation 20 was discharged existed. There was evidence of learning in respect of how the service applied the requirements of the duty of candour regulation had previously been applied and how processes had been amended to ensure best practice in future cases.

**Safety thermometer**

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

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcer,
no fall with harm and no new urinary tract infection in patient with a catheter from December 2016 to December 2017 for children’s services.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

We reviewed a range of policies and procedures to determine whether they were aligned to national best practice and were evidence based. Whilst some policies were consistent with such guidance, including the use of paediatric early warning tools, a number of care bundles had not been updated to reflect changes to guidance. Examples included the management of the febrile child. We noted nursing staff administering paracetamol to a child who had a low-grade pyrexia of 38 degrees. The care bundle used was based on guidance dating back to 2013 and had not been updated to the most recent 2017 guidance, which recommends anti-pyretic medication should not be administered unless the child was showing signs of distress; this was not the case in the scenario we observed.

As reported within the safe domain, it was noted that whilst the service had tools in place to demonstrate compliance with evidence based care and treatment; these were not always consistently used, as in the case of visual infusion phlebitis and peripheral venous cannula management. Senior members of the nursing team acknowledged that more work was required to ensure staff consistently used such tools to help protect and promote the welfare and safety of children.

We were informed that due to staffing restraints, there was limited capacity amongst the medical workforce to conduct audit activity to demonstrate staff were consistently applying evidence-based care. We asked the trust to provide us with audit activity within children’s services at Pilgrim hospital however we were only provided with an assessment of the trust’s compliance with the Royal College of Paediatrics and Child Health “Facing the Future” standards.

The neonatal unit had retained its accreditation with the UNICEF baby friendly initiative, which was aimed at supporting breast feeding and improving parent-infant relationships.

Nutrition and hydration

Staff had access to a qualified dietician who was able to provide advice and support on an ad-hoc basis. We noted the service was not equipped to manage patients who required parenteral nutrition and so treatment for such patients was often conservative until such a time that referrals could be made for children to be transferred to tertiary paediatric centres for on-going management.

Staff reported they used national based pre-operative starving time protocols prior to children undergoing general anaesthetic. Children were either scheduled for paediatric dedicated theatre lists or were placed at the beginning of adult lists in order they were not starved for extended periods of time. We could not fully assess compliance with starving times because there was no formalised audit activity to determine whether children experienced delays in undergoing surgery and therefore whether children experienced extended pre-operative starving periods. We reviewed the case notes for one child who had undergone emergency surgery and found they had been starved in line with national standards.
A number of neonatal nurses were also qualified as midwives, with a small number having undertaken additional training to enable them to provide breast-feeding advice and support to new mothers.

**Pain relief**

Staff working in the recovery department were able to reference a number of age specific pain management tools which they were able to use for post-operative children. We reviewed the case notes for one child who had undergone emergency surgery on the first day of inspection. Recovery staff had recorded pain scores for the patient and had taken appropriate action to manage the child’s pain level whilst they remained in the recovery area.

Ward staff were able to also reference age specific pain assessment tools for children and young people. Staff were conversant with best practice pain management and could describe the pain and analgesia ladder.

There was evidence staff working on the special care unit used appropriate pain assessment tools for neonates. Staff could access sucrose for the management of pain in minor procedures although we noted the hospital had no stock of sucrose on the evening of the first day of inspection.

**Patient outcomes**

**Paediatric diabetes audit 2015/16**

Pilgrim Hospital Boston

The data below shows that in the 2015/16 diabetes audit Pilgrim Hospital Boston performed similar to the England average.

The proportion of patients receiving all key care processes annually was 0% which was significantly worse than expected, compared to a national aggregate of 35.5%, the previous year’s score was 0%.

We discussed the outcomes of the paediatric diabetes audit with the clinical service lead. They reported they had undertaken a look-back exercise to ascertain why performance against a number of audit criteria was worse than expected. We were informed that data quality had contributed to the poor performance and that an action plan had been established to ensure correct data was submitted in future audits.

The average HbA1c value (adjusted by case-mix) at the trust was 65.6% which was within the expected range, compared to a national aggregate of 68.3%, the previous year’s score was better than expected.

The median HbA1c value recorded amongst the 2015/16 sample was 64, which was similar to the previous year’s median which was 65.

*(Source: National Paediatric Diabetes Audit 2015/16)*

**Emergency readmission rates within two days of discharge**

There were no emergency readmission cases of six or more readmissions which took place from June 2016 to May 2017 for either age group ‘under ones’ or for ‘patients aged 1-17 years old’ who would have been readmitted following an elective admission compared to the England average.
The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from September to August 2017 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average and a lower percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

### Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty
(September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.8%</td>
<td>1,906</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

### Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty
(September 2016 to August 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>2.1%</td>
<td>3,902</td>
</tr>
<tr>
<td>General Surgery</td>
<td>2.0%</td>
<td>441</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

**Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes**

From October 2016 to September 2017 the trust performed better than the England average for the percentage of patients aged 1-17 years who had multiple readmissions for epilepsy.

The trust performed worse than England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma.

The trust performed similar to the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for diabetes.
Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years).

(October 2016 to September 2017)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>United Lincolnshire Hospitals NHS Trust</th>
<th>England Multiple admission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>22.1%</td>
<td>104</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>20.0%</td>
<td>45</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>1 to 17</td>
<td>21.7%</td>
<td>46</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

National Neonatal Audit Programme

Pilgrim Hospital Boston

In the 2016 National Neonatal Audit Pilgrim Hospital Boston performance was as follows:
Do all babies < 1501g or a gestational age of < 32 week at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

There were 15 babies born with a birth weight <1501g or with a gestational age at birth <32 weeks who were assigned to this unit for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window*; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

There were 192 first episodes of care that were eligible for inclusion in this audit measure for this unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 89% of the eligible episodes; this was below the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Are rates of normal survival at two years comparable in similar babies from similar neonatal units?

There were 10 babies born at <30 weeks born between July 2013 and June 2014 who have been assigned to this hospital for two-year health assessment based on their final neonatal discharge.
Data was entered for 0% of the babies assigned to this unit, whilst nationally data was available for 61% of babies born at <30 weeks born between July and June 2014.

What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?

There were 49 babies born <32 weeks in this hospital who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies ten were identified as having Significant BPD.

*(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)*

**Competent staff**

**Appraisal rates**

From April 2017 to October 2017, 88% of staff within children’s service at the trust had received an appraisal compared to a trust target of 85%.

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

During our inspection in 2017 we found there was no formal mechanism by which staff received clinical supervision. At this inspection, we spoke with a range of staff regarding clinical supervision availability. Three members of staff told us that whilst the matrons and clinical lead were available to discuss specific cases, no formalised clinical supervision arrangements remained. We were told of a significant child safeguarding case which had occurred prior to the inspection; two members of staff involved in the management of the child said they would have welcomed the opportunity for a clinical supervision session to discuss the case in full as they had been emotionally affected by the case; formal debriefing and clinical supervision had not occurred at the time of the inspection.

We observed a medical handover on the second day of our inspection. The last ten minutes of the session was dedicated to facilitated training with a senior trainee providing a teaching session to the more junior members of the team. Staff reported that this was a welcomed session as it enabled staff to explore clinical conditions they may not have previously come across during their clinical training.

Whilst there was support for new staff on the special care baby unit, there was no such role within the children’s ward. The senior nursing team had acknowledged a need for a practice development nurse and so had created a business case for funding of such a role. As an interim measure, the matron and deputy matron had planned scenario training for ward based staff as well as ensuring new members of staff had a peer or buddy to work alongside whilst they became familiar with the ward.

**Multidisciplinary working**

**CQC Children and Young People’s Survey 2016 – Q36**

In the CQC Children and Young People’s Survey 2016 the trust scored 8.30 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*
We observed some good examples of where various health professionals worked together to ensure appropriate delivery of care for children and young people. Clinical handovers each morning was attended by both medical staff and the nurse in charge for the ward to ensure both professions were sighted on treatment plans for inpatients. Children with complex needs underwent formal multi-disciplinary meetings attended by both community and acute nursing staff, lead paediatrician, the family and other health professionals as necessary.

There were appropriate clinical pathways within the region to ensure children were referred and transferred to tertiary centres as required. The children’s ward operated as a level one paediatric oncology shared care unit and so was able to admit children undergoing acute oncology treatment should they present with acute symptoms such as febrile neutropenia; this reduced the need for children to be transferred to their tertiary centre which could often be some distance from their home.

**Seven-day services**

The children’s service accepted they could not meet the Royal College of Paediatrics and Child Health “Facing the Future” staffing standards due to the reduced number of consultant paediatricians employed by the service. However, consultant paediatricians conducted daily ward rounds with on-call arrangements in place to ensure out-of-hours cover. Where consultants lived more than thirty minutes from the hospital, there was a process in place for providing on-site accommodation to enable a quick response should a clinical situation arise.

Staff could make referrals to support services including radiology and physiotherapy out of hours.

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

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

The trust reported that from April 2017 to October 2017, Mental Capacity Act (MCA) training had been completed by 85% of staff within children’s service.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses</td>
<td>126</td>
<td>150</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>34</td>
<td>41</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust have confirmed that the deprivation of Liberty training is included in the mental capacity act training module within the mandatory training data provided by the trust.

(Source: Routine Provider Information Request (RPIR) Training)

Ward based staff were able to describe the processes they would work through to seek consent from children and young people. Staff were conversant with national practices relating to consent including the concept of Gillick competence. We reviewed the case notes for one post-operative child; the risks and benefits of surgery had been recorded and consent had been obtained from a
person with parental responsibility. Staff could describe the process of seeking consent from those with parental responsibility where a child was for example, in the formal care of social services.

We observed nursing staff obtaining consent from parents prior to taking blood samples for the national baby screening programme. Where parents did not speak English, we observed staff using a list of common phrases to describe the conditions the baby would be screened for, as well as using language line, a telephone interpreting service, to ensure parents understood the procedure and rationale for screening.

**Other CQC survey data**

**CQC Children and Young People’s Survey 2016 Data**

The trust performed about the same as other trusts for all six questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children’s Survey questions, effective domain, United Lincolnshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.70</td>
<td>About the same as other trusts</td>
<td>E3</td>
</tr>
<tr>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>6.72</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.91</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.92</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>7.05</td>
<td>About the same as other trusts</td>
<td>E4</td>
</tr>
<tr>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>No Score</td>
<td>No Score</td>
<td>E4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Is the service caring?

Compassionate care

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for the remaining ten questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, compassionate care, United Lincolnshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.99</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>9.08</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.29</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.09</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>8.95</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.44</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>6.03</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>8.30</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 CYP</td>
<td>9.38</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
<tr>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 CYP</td>
<td>9.09</td>
<td>About the same as other trusts</td>
<td>C1</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Parents we spoke with were complimentary about the care and treatment their child had received. Two children told us the nursing and medical staff had been kind and had explained procedures before they were undertaken.

We observed staff from different clinical settings, including radiology, speaking to children, using age appropriate language. Staff adapted their body language, for example, bending down to make eye contact with the child; this demonstrated an understanding of the needs of the child and is consistent with best practice.
Children and parent’s privacy and dignity were maintained at all times and we saw staff close curtains and side rooms doors to do so.

**Emotional support**

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for one question, and about the same as other trusts for the remaining four questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

The question ‘were you given enough privacy when you were receiving care and treatment?’ scored better than other trusts.

**CQC Children and Young People’s Survey 2016 questions, emotional support, United Lincolnshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.28</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.50</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.24</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>9.46</td>
<td>Better than other trusts</td>
<td>C3</td>
</tr>
<tr>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>8.82</td>
<td>About the same as other trusts</td>
<td>C3</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

The trust provided both community and acute children’s services. The community children’s team had a well-established palliative care team who provided care to children with long-term complex needs. Whilst the community team was not subject to inspection, we considered the input and engagement the team had with acute inpatient services. Staff told us the community team were accessible and were able to provide support to both staff and families when children with long term needs were admitted to the ward. Whilst the need was rare, staff knew they could access the palliative care team to support children and family members when a child was nearing the end of their life.

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

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for the 21 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.
<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>9.03</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.70</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>9.09</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.37</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.94</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.38</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>9.15</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.57</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.37</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>8.74</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>0-15 adults</td>
<td>7.63</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.47</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 CYP</td>
<td>9.19</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>8.35</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did you feel able to ask staff questions?</td>
<td>8-15 CYP</td>
<td>9.43</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Did the hospital staff answer your questions?</td>
<td>8-15 CYP</td>
<td>9.38</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>Were you involved in decisions about your care and treatment?</td>
<td>8-15 CYP</td>
<td>6.30</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
<tr>
<td>If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?</td>
<td>12-15 CYP</td>
<td>9.59</td>
<td>About the same as other trusts</td>
<td>C2</td>
</tr>
</tbody>
</table>
Before the operations or procedures, did hospital staff explain to you what would be done? 8-15 CYP 9.70 About the same as other trusts C2

Afterwards, did staff explain to you how the operations or procedures had gone? 8-15 CYP 7.99 About the same as other trusts C2

When you left hospital, did you know what was going to happen next with your care? 8-15 CYP 8.41 About the same as other trusts C2

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Nursing staff told us their approach to providing nursing care was based on a recognised model of family centred care. Our observations of nursing care during our two-day inspection was that both the child and family members were treated as one unit. The perspectives of children and their families were considered during ward rounds.

Nursing staff were observed supporting parents and children by providing information and advice which was both age appropriate and in a language which was easy to understand and not complicated with medical terminology. Staff took the time to speak with families to explain procedures before they commenced.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for the 17 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, responsive domain, United Lincolnshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.79</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?</td>
<td>0-15 adults</td>
<td>9.21</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>9.42</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>5.75</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.61</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>7.69</td>
<td>About the same as other trusts</td>
<td>R1</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>8.01</td>
<td>About the same as other trusts</td>
<td>R2</td>
</tr>
</tbody>
</table>
The trust had made a decision to reduce the total number of inpatient beds to twelve and then subsequently to eight shortly prior to our inspection. This was based on the fact the trust was having difficulty recruiting and retaining suitably skilled and qualified nursing staff. There had been little thought given to the impact of such a reduction to the needs of the children within the local area. Whilst arrangements had been made for those children requiring admission, to be transferred to Lincoln County Hospital should the children’s ward at Pilgrim Hospital be full, we found that on the second day of our inspection, Lincoln County had confirmed they were also at full capacity and so was closed to admissions. We noted that two children in the emergency department at Pilgrim Hospital required further investigation and so the lead consultant had opted to transfer the children to the ward until such time that relevant investigations had taken place. Discussions with the lead clinical commissioner confirmed they had undertaken an analysis of bed occupancy at Pilgrim Hospital over the preceding years and had determined the ideal number of beds required at Pilgrim hospital to ensure the hospital met the needs of the public was twelve beds. A paper from the trust also confirmed “There will be a significant number of days when the service will have more than eight children requiring admission”.

Staff reported the decision to reduce the total number of beds had been a difficult decision but considered it to be the right decision as an interim safety measure. We were concerned with the lack of system planning and risk mitigations. The reduction in beds had not been fully communicated to the wider health system; arrangements had not been put in place for admission

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
avoidance schemes to be established prior to the closure of beds and patients waiting for elective surgical procedures had not been fully considered.

Three patients had been identified as being at high risk and so had been clinically prioritised for surgery at another location. A further 172 patients were awaiting surgical procedures. At the time of the inspection, staff were not able to confirm whether those children had been subject to clinical prioritisation or clinical triaging. A response from the trust following the inspection stated “Patients have been reviewed by the relevant consultant. Specialities are continuing to review all patients with a view to prioritising activity. Those cases deemed as urgent will then be escalated and will if appropriate be transferred to Lincoln County Hospital”. We considered the trust had not fully assessed the impact of closing beds with limited consideration given to surgical patients prior to the bed closures.

The trust was monitoring the number of transfers carried out following the closure of beds. They reported there may have been a possible marginal increase in the number of transfers in the first week following the reduction of beds, but that this trend had not continued in to March. The dataset did not allow the trust to identify which site children were transferred too and so it was difficult to ascertain whether Lincoln County had seen an increase in referrals to them following the bed closures. The trust had seen an increase in waiting times for children attending the emergency department at Pilgrim Hospital. Prior to the bed closures, the median total time spent in the ED was as follows:

<table>
<thead>
<tr>
<th>Median (time in HH:MM)</th>
<th>11/02/2018</th>
<th>18/02/2018</th>
<th>25/02/2018</th>
<th>04/03/2018</th>
<th>11/03/2018</th>
<th>18/03/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Admitted</td>
<td>1:41</td>
<td>2:10</td>
<td>2:24</td>
<td>2:19</td>
<td>2:57</td>
<td>2:17</td>
</tr>
<tr>
<td>Time to Triage - 999 patients</td>
<td>0:59</td>
<td>0:39</td>
<td>0:05</td>
<td>0:06</td>
<td>0:14</td>
<td>0:14</td>
</tr>
<tr>
<td>Time to Treatment</td>
<td>1:07</td>
<td>1:05</td>
<td>1:23</td>
<td>1:07</td>
<td>2:04</td>
<td>1:22</td>
</tr>
</tbody>
</table>

The longest time periods prior to and following the bed closures had also increased:

<table>
<thead>
<tr>
<th>Longest (time in HH:MM)</th>
<th>11/02/2018</th>
<th>18/02/2018</th>
<th>25/02/2018</th>
<th>04/03/2018</th>
<th>11/03/2018</th>
<th>18/03/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted</td>
<td>5:18</td>
<td>9:53</td>
<td>8:04</td>
<td>6:01</td>
<td>10:12</td>
<td>8:24</td>
</tr>
<tr>
<td>Time to Triage - 999 patients</td>
<td>1:43</td>
<td>1:03</td>
<td>0:58</td>
<td>0:15</td>
<td>2:28</td>
<td>2:08</td>
</tr>
<tr>
<td>Time to Treatment</td>
<td>3:23</td>
<td>4:58</td>
<td>5:53</td>
<td>5:38</td>
<td>7:16</td>
<td>7:59</td>
</tr>
</tbody>
</table>

Staff raised concerns with us that children requiring admission were having to wait longer in the emergency department due to the limited number of beds; data provided by the trust confirmed median waiting times were increasing. We had raised concerns with the trust over the competency of nursing staff working in the emergency department (please see the emergency care report for further details). We considered therefore the bed closures had further increased the risk to children within the emergency care pathway. At the time of the inspection, the trust was not
considering the wider risks from a holistic perspective and so we asked the trust to take action to risk assess and mitigate, as they considered necessary.

**Meeting people’s individual needs**

There had been a level of needed investment in facilities for parents; new fold-away beds had been purchased as an example of where historical tight financial control had had an impact on service users and their family. The leadership team recognised the need for the ward to be re-decorated. The environment was dark, with art work on walls which was incomplete. We were advised the commissioned artist was not planning to return to complete the contracted works and so there was a hiatus in walls being decorated.

At our inspection in 2017, we noted signage for the special care baby unit to be misleading when exiting the lifts from the 4th floor. Signage remained in situ at this inspection and therefore continued to be misleading. As visitors exited the lift foyer, a sign directed people to a set of double doors which were locked, with no buzzer available. Access to the special care baby unit was in fact via the children’s ward or alternatively via the maternity unit. Parents or visitors visiting the special care baby unit may find this signage to be confusing, especially during times when people may be anxious about their baby being admitted to the special care unit.

Within the outpatients and radiology departments, there was dedicated provision for children and young people. Both areas were equipped with age appropriate toys.

The trust was working to increase the provision of transitional care clinics for adolescents however this remained a work in progress at the time of the inspection. The trust had a well-established diabetes transition clinic which was described as functioning well with timely referral of young people to the adult diabetes service.

Both the children’s ward and the special care baby unit had parent facilities which enabled parents to prepare hot drinks, to spend time away from the bed or cot side and to meet other parents. There were arrangements in place for supporting parents whose child or baby was admitted for long periods, with the costs of parking.

An adolescent room was available on the children’s ward which was equipped with television and games consoles.

**Learning from complaints and concerns**

**Summary of complaints**

From October 2016 to September 2017 there were 23 complaints about children and young people care from a total of 750. The trust took an average of 47.3 days to investigate and close complaints; this is not in line with their complaints policy, which states complaints should be completed within 35 days (80% of them) and complex complaints should be responded to within 50 days. The categories most used to report complaints for children’s services were delay or failure to diagnose (inc e.g. missed fracture) and communication with relatives/carers.

- Pilgrim Hospital Boston: There were seven complaints

(Source: Routine Provider Information Request (RPIR) P61 Complaints)
Is the service well-led?

Leadership

There had been an element of management churn since our last inspection. Both the long-standing matron and ward manager for children’s services had left the service with interim post-holders in both posts at the time of the inspection. The matron for community children’s services had been asked to cover acute services and they had been doing so for approximately eleven months. They were supported by a deputy matron who was also the lead for community palliative care services. The trust had appointed a new clinical service lead for children’s services; the post holder was a substantive consultant who was well-versed with the role of clinical service lead having previously been the lead for neonatal services. At the time of the inspection, there was no clinical director in post for women’s and children’s services, with the previous post holder having left the trust in January 2018. The trust had not yet recruited a replacement to this post at the time of the inspection.

Staff reported local leadership was visible and supportive.

Vision and strategy

We reported within our last inspection report (April 2017) that staff were concerned with the future of children’s services at the trust and specifically at Pilgrim Hospital. This was in part due to the recognition of the challenges faced by the service in regards to its sustainability and continued recruitment and retention challenges. Whilst the trust had devised a five-year strategy which included plans for children’s services, staff had previously reported the need for improved flow of information and better communication from senior members of the team. At this inspection, there had been little movement in regards to confirming the long-term strategy for children’s services.

Staff continued to report concerns about the future of children’s services at Pilgrim Hospital. A number of senior clinicians acknowledged the need for change, we consideration given to moving from an acute in-patient service to an short-stay paediatric assessment unit and a shift of elective surgical activity to Lincoln County Hospital. These changes to service delivery were aligned with those of the STP. However, staff reported there had been little in the way of communication about this. This was partly due to the fact STP leads had not finalised the changes to service delivery, with plans still subject to consultation and sign off from NHS England.

Staff described an element of planning blight or hiatus in regards to the need for the STP to agree a long-term solution. Front line staff were aware of the challenges they faced with senior members of the team reporting a large proportion of their time was spent on recruitment activities which have proven to be almost fruitless at the time of inspection. There were concerns that unless sufficient numbers of both medical and nursing staff could be recruited and more importantly, retained, the future of children’s services at Pilgrim Hospital was unsustainable. Whilst local clinical leaders had ideas about the type of service they felt they could run with the limited human resources available to them, they reported they did not feel listened too and were concerned that plans were being developed without their engagement or involvement.

It was apparent that local leaders had escalated risks to the board. However, it was not clear how the board was taking control of those risks. There was little in the way of commentary at board level about the risks faced by children’s services. Whilst local commissioners and the STP had developed plans for the future of children’s services, it appeared there was a lack of priority or pace within the local health system to resolve what was a long-standing and critical problem.

Culture
There existed a feeling of low morale within the nursing workforce, in part compounded by a sense of lack of future direction of paediatric in-patient services at Pilgrim Hospital. Whilst senior leaders reported actions such as “Sending virtual hugs” to staff through emails and letters explaining that roles would be secured in the long term, this had had little impact on front-line staff.

Staff told us the departure of the previous ward manager and matron had created an opportunity for the service to reconfigure, and to consider modernising ways of working. Tight financial control had resulted in staff losing the confidence to request new items such as parent beds; this culture had shifted with the appointment of the interim matron who had undertaken an extensive capital expenditure programme to replace ageing equipment. This was welcomed by ward staff. Some staff reported the new nursing leadership team had created a momentum within children’s services. There was a drive to modernise nursing practice, which some considered to be out of date and not aligned to current best practice. The matron and deputy matron had worked closely with the local university to develop a link-lecturer role who was shortly to be awarded an honorary contract to enable the post holder to work alongside ward staff to help develop nursing skills and knowledge base.

**Governance**

The Women’s and Children’s Directorate had a defined governance structure which was set out in the Women’s and Children’s Business Unit Governance Committee (Pan Trust) terms of reference which had last been reviewed in June 2017. However, during the inspection staff reported the Children and Young People’s Board, for which the Women’s and Children’s Business Governance Committee was due to report to, at least, in part, was not currently taking place. This was confirmed by the trust by way of an action plan, which was submitted to CQC and dated 19 March 2018. The action plan listed the “Relaunch of the Children and Young People’s Board” as a defined action to take place by 23 March 2018.

The Royal College of Surgeons Standards for Children’s Surgery (2013) sets out a range of guiding principles to help support organisations to deliver surgical activity within a safe and appropriate environment. It was recommended that a defined governance structure existed to assure the board of the quality and delivery of surgical care to children and that this should be overseen by a multi-disciplinary children’s surgery committee which reported to the board. At the time of the inspection such a committee or governance structure did not formally exist and there was no reference to such a committee within the terms of reference referred to above. The service lead for acute paediatrics confirmed their remit did not extend to overseeing the children’s surgical care pathway.

Monthly governance meetings took place within both neonatology and paediatrics, both of which had set agendas covering performance and safety, patient experience, clinical effectiveness, education and training, risk registers and safeguarding. A review of minutes for September, October and November confirmed good attendance at each meeting with apologies provided. Whilst there was commentary in the minutes for the majority of agenda items, some items remained blank for each month including safeguard, good practice and concerns to escalate from the meeting. It was therefore not possible to determine whether these items were routinely discussed or not. We noted the minutes for neonatal governance meetings were considerably more comprehensive and useful in terms of providing an audit trail for staff as to what had been discussed and agreed actions.

**Management of risk, issues and performance**
The service had a dedicated risk register which contained ten risks covering both Pilgrim Hospital and Lincoln County hospital. The oldest risk dated back to December 2007 and related to the management of violent children on children’s wards. The risk was graded as high with a current score of 9. The concern was that there would not be sufficient numbers of staff to provide appropriate levels of supervision to children. The controls in place included the use of additional staff or carers to provide supervision. The mitigation detailed the use of carers from external agencies being “taken on trust, as suitable” to provide supervisor care to patients. The use of security staff or police for extreme restraint situations was also listed as mitigation. Remaining risks were linked to either staff availability, recruitment of staff, or skill set of staff. Mitigations were in place for each risk with evidence of regular review. However, as previously discussed there was little in the way of contingency plans, nor was it possible to determine how mitigations were being evaluated to determine their effectiveness.

Staffing levels and the retention and recruitment of skilled and qualified staff had existed for some two years prior to the inspection. The trust had held a number of internal risk summits to consider the impact and implications however there had been little in the way of effective management of the situation. Senior members of the nursing team considered they had reached a critical point in August 2017 and escalated the matter to the board. A presentation to the private section of the board in September 2017 set out the staffing concerns. The board agreed they would support the escalation of concerns to community stakeholders on 6 September 2017 and that the matter had been listed as resolved within the private board papers of 5 September 2017. Discussions with the lead commissioner confirmed that consideration was being given to the future of children’s services as part of the sustainability and transformation plan however there was currently no definitively agreed strategy. We considered the lack of grip and management of an evolving risk presented a risk to the safety and welfare of the local population. In considering the fact the trust had known about the recruitment issues for some significant time, and the fact that despite the best efforts of the local leadership team to recruit and retain staff, there was little in the way of long term strategy or effective management of risk. Previous mitigations had not delivered the desired number of nurses and doctors. Whilst leaders were continuing to try and firefight the challenges of recruitment and retention, the trust had not considered nor implemented contingency plans in a cohesive and timely way. The closure of beds had come at a time when staffing levels had reached a critical level. It is the view of the Commission that such a reduction of beds should have taken place in a planned and co-ordinated way, with alternative care pathways being established prior to the reduction, in order risks could be mitigated as best as possible.

We also noted that whilst daily meetings occurred through video-link in which nursing staff discussed areas of risk including staffing challenges, there was little in the way of integrated service risk management. For example, in December 2017, ward 4A at Pilgrim hospital reported not one day in which a day shift was coverage to provide 100% of planned care hours by a registered nurse. This differed from rainforest ward at Lincoln County Hospital in which planned hours of care was provided by a registered nurse at or more than 100% on sixteen days. On three days planned hours of care was exceeded by 100%. On the 5th December ward 4a provided 64% planned hours of care versus 122% hours being provided on Rainforest ward. Staff reported there were cultural challenges with asking staff to move between hospitals to cover shifts and so requests were only made on infrequent occasions.

Staff used a quality safety performance dashboard to help assess the quality of care provided on the ward. The dashboard captured information including whether lifesaving equipment was routinely being checked; security of medicines; whether patients were reviewed within four hours of admission; compliance of risk assessment tools including paediatric early warning scores, skin
integrity and visual infusion phlebitis tools. Where performance was seen to be poor, there was discussion minuted within the monthly governance meeting to consider what additional focus was required to enhance quality and safety. What was not included on the dashboard was areas such as staffing levels, complaints and incidents; the dashboard was therefore not giving a completely comprehensive view of the service and so contributing factors may not always be quickly recognised.

**Information management**

Paper based patient records were used across the service. We noted a white board on the children’s ward which was viewable to all visitors. The board include patient names, bed number, whether a child was receiving intravenous infusion therapy, whether they were receiving antibiotics and whether they were nil by mouth. The board was also used to capture other information such as whether the child was ready for discharge. We raised concerns with the nursing leadership team that such information could be breaching patient confidentiality and so they took action to remove sensitive information from the white board on the first day of the inspection.

**Engagement**

Staff reported they had not been fully engaged with the discussions regarding the future of children’s services at Pilgrim Hospital. There was a willingness amongst the workforce to consider the future of children’s service, and for then to work alongside the trust and commissioners to consider the most appropriate and realistic care pathway at Pilgrim hospital however staff felt their views had not been considered or taken in to account.

**Learning, continuous improvement and innovation**

Medical handovers allowed a period of continuous learning for junior doctors. Simulation training had been scheduled for 2018 to help enhance nursing and medical skills such as the management of a deteriorating child.

There was a strong realisation amongst the nursing leadership team that significant work was required to improve the clinical competence and knowledge base of the workforce. Arrangements with the local university as well as developing networks with neighbouring children’s hospitals would help develop strong working relationships which could be used to support such development of the nursing workforce in the future; these relationships were being developed at the time of the inspection but were not yet in place.
Outpatients

Facts and data about this service

The United Hospitals of Lincolnshire NHS Trust provided outpatient services at the Pilgrim Hospital. Pilgrim Hospital, Boston is a large district general hospital located on the outskirts of Boston. Outpatient clinics included the following specialties: cardiology, maxillofacial, haematology, orthopaedics including a fracture clinic, nephrology, urology, pain management, general medicine, general surgery, dermatology, respiratory and ophthalmology. The trust provided outpatient services at other locations in the county, including Lincoln County Hospital and Grantham Hospital.

Trust level data in this appendix will cover all three locations but data will only be split down to location level for Lincoln County Hospital and Pilgrim Hospital – the two hospitals to be inspected.

Total number of appointments compared to England

The trust had 671,404 first and follow up outpatient appointments from October 2016 to September 2017. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from October 2016 to September 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>462,768</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>306,322</td>
</tr>
<tr>
<td>Grantham &amp; District Hospital</td>
<td>130,555</td>
</tr>
<tr>
<td>County Hospital Louth</td>
<td>35,793</td>
</tr>
<tr>
<td>Johnson Hospital</td>
<td>29,976</td>
</tr>
<tr>
<td>This Trust</td>
<td>997,417</td>
</tr>
<tr>
<td>England</td>
<td>103,794,079</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
Number of appointments by specialty

The chart below shows the number of outpatient attendances for the trust by speciality from August 2016 to July 2017.

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from October 2016 to September 2017. The percentage of these appointments by type can be found in the chart below:

Number of appointments at United Lincolnshire Hospitals NHS Trust from October 2016 to September 2017 by site and type of appointment.

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust set a target of 90% for completion of the majority of mandatory training however some modules had a higher target which can be seen in the table below.

Training rates for medical staff were reported within the individual directorates.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and health visiting staff in outpatients is shown below:

Pilgrim Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud Awareness</td>
<td>45</td>
<td>45</td>
<td>100</td>
<td>95</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>45</td>
<td>44</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>45</td>
<td>44</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>45</td>
<td>44</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>45</td>
<td>43</td>
<td>96</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>45</td>
<td>43</td>
<td>96</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>45</td>
<td>41</td>
<td>91</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>45</td>
<td>41</td>
<td>91</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>45</td>
<td>41</td>
<td>91</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>45</td>
<td>37</td>
<td>82</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>45</td>
<td>32</td>
<td>71</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>15</td>
<td>0</td>
<td>N/A</td>
<td>90</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital the trust’s target was not met for five out of the 11 eligible training modules for qualified nursing staff and health visiting staff. The lowest training compliance was for major incident awareness training (71.1%).
Pilgrim Hospital – Support Staff (including Health Care Support Workers and Administration Staff)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud Awareness</td>
<td>114</td>
<td>108</td>
<td>95</td>
<td>95</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>114</td>
<td>112</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>114</td>
<td>110</td>
<td>96</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>114</td>
<td>111</td>
<td>97</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>114</td>
<td>109</td>
<td>96</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>114</td>
<td>101</td>
<td>88</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>114</td>
<td>105</td>
<td>89</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>114</td>
<td>102</td>
<td>89</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>114</td>
<td>105</td>
<td>89</td>
<td>95</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>114</td>
<td>94</td>
<td>82</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>114</td>
<td>95</td>
<td>83</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>90</td>
<td>N/A</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital the trust’s target was not met for six out of the 11 eligible training modules for qualified nursing staff and health visiting staff. The lowest training compliance was for major basic life support (82%). Whilst we were on inspection we saw additional sessions for basic life support were planned for the following month for all staff groups.

All staff we spoke with said they had completed their mandatory training and were up to date. Mandatory training consisted of a mixture of face-to-face training and electronic learning packages. The trust included awareness of the potential needs of patients with mental health conditions, learning disabilities, autism and dementia in the mandatory training programme.

(Source: Routine Provider Information Request (RPIR) – Training)
Safeguarding

Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff through mandatory training.

The Director of Nursing was the executive lead for safeguarding trust wide. Policies, procedures, protocols and frameworks relating to safeguarding were in place and staff told us they were easily accessible.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training on how to recognise and report abuse and they knew their responsibilities about putting this into practice. Staff gave examples of when they had raised safeguarding concerns. For example, staff working within the fracture clinic had raised safeguarding concerns about an injury to a child and had worked with the safeguarding lead and the inpatient children’s ward to ensure the child was protected from abuse.

The trust had safeguarding ‘champions’. We spoke with members of staff who were ‘champions’ for the outpatient’s department. They confirmed they had quarterly meetings, fed back important safeguarding information to other members of staff at the ‘time to talk’ daily meetings and kept the patient information boards in the waiting areas up to date. We saw current information displayed relating to female genital mutilation, (FGM), domestic violence and child abuse on these boards. We saw similar information displayed on the staff notice board, in addition there was information on contact details for the various safeguarding agencies.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training from April 2017 to October 2017 for qualified nursing and health visiting staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>45</td>
<td>44</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>45</td>
<td>44</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>45</td>
<td>44</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>45</td>
<td>44</td>
<td>98</td>
<td>90</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>18</td>
<td>17</td>
<td>94</td>
<td>90</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all safeguarding training modules for which qualified nursing and health visiting staff were eligible at and Pilgrim Hospital.

Pilgrim Hospital – Supporting Staff (including Health Care Support Workers and Administration Staff)
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>114</td>
<td>96</td>
<td>84</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>56</td>
<td>38</td>
<td>68</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>114</td>
<td>95</td>
<td>84</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>56</td>
<td>38</td>
<td>68</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The 90% target was not met for all safeguarding training modules for which support staff were eligible at Pilgrim Hospital.

All staff we spoke with had up to date safeguarding adults and children training. The trust trained nursing and non-nursing staff to level two safeguarding children. Qualified staff involved in the care of children within outpatients were trained to level three.

Prevent Duty training was mandatory for staff and included in both children and adults safeguarding training. The aim of Prevent is to give staff an awareness and knowledge of what extremism and radicalisation are and how people may be drawn into terrorism.

Training rates for medical staff were reported within individual directorates

(Source: Routine Provider Information Request (RPIR) – Training)

Cleanliness, infection control and hygiene

There were reliable systems in place to prevent and protect people from a healthcare-associated infection.

Staff had access to a range of infection prevention and control policies, procedures and guidelines, which were available on the trust’s intranet site. We saw staff adhere to these policies in relation to hand hygiene and infection control. For example, we saw staff observed the ‘bare below the elbow’ rule and did not wear watches or jewellery in clinical areas. We observed staff using the personal protective equipment (PPE) provided when providing treatment and care including aprons and gloves.

During our inspection we saw the majority of clinical areas were visibly clean. Infection control was included as part of the monthly quality assurance audits, which started in August 2017. We saw the results of the audits for 1st February 2018 for the main outpatients department, which were 100% for hand hygiene, 95% for cleaning schedules and 93.3% for the housekeeping audit.

Not all of the non-public areas that administration staff worked in were visibly clean and some did not appear to be well maintained. For example, we saw carpets in some of the medical secretaries’ offices and administration areas were damaged or badly marked.

The trust had a policy for changing curtains in clinical areas regularly or when visibly soiled. Most curtains we checked were visibly clean and changed in line with trust policy. However, we saw some curtains were not disposable and did not appear to have been changed for some time, for example within the phlebotomy clinic. We could not determine exactly how long because there were no dates for replacement displayed on them. This presented a possible infection control risk to staff and patients.
Environment and equipment

Overall, the design and maintenance of the environment kept people protected from avoidable harm. Outpatient services were delivered on the ground floor, with a dedicated entrance. These meant clinics were easily accessible to patients without the use of lifts or stairs. Fire exits were clearly marked and corridors and clinic waiting rooms were generally free from clutter.

However, services were delivered in an older building which meant parts of the environment presented challenges in delivering services. Some of the waiting areas were small and became overcrowded at times of peak activity. For example, we saw the waiting area for the phlebotomy (blood test) area was very small and crowded. Fire regulations dictated waiting room for 18 patients including two wheelchairs. Staff told us there would regularly be more than that number of people waiting. We spoke with two patients waiting for blood tests who used the service on a regular basis. They told us there was often long waiting times and crowded environment. The waiting area for the waiting area in the eye clinic was too small for the numbers of patients being seen and patients were asked to wait in the main waiting area. Staff working within the ear, nose and throat speciality told us of the lack of office space and no staff room.

There were reliable systems in place to ensure emergency equipment was regularly checked and available in the event of an emergency. Emergency equipment was easily accessible and we saw staff checked the equipment on the resuscitation trolley daily. Paediatric ‘grab bags’ were available on trolleys within areas that cared for both adults and children. We checked five resuscitation trolleys and observed the checklists were completed, dated and signed daily and the equipment and consumables stored on them were sterile and within the expiry date.

There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy. We saw sharps bins labelled, initialled and dated in accordance with national guidance. Staff disposed of clinical waste in dedicated colour coded bags in the dirty utility.

The service had procedures in place to check, test and service equipment. We checked 20 pieces of equipment. All equipment had been tested and checked in accordance with trust policies. We observed staff cleaning and wiping down equipment before, after and in-between clinics.

Assessing and responding to patient risk

When we inspected the outpatient department in October 2016 we found there was no system in place to monitor and manage the risk to patients on the waiting list. This meant the hospital was failing to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients on the waiting list.
Since our previous inspection the trust had introduced a process to review the harm that may have been caused to some patients as a result of longer waiting times. We reviewed the outpatient harm review standard operating procedure (SOP) which specified the criteria of patients to be reviewed. Since our previous inspection, the trust had introduced a process to review the harm that may have been caused to some patients as a result of longer waiting times. We reviewed the outpatient harm review standard operating procedure (SOP) which specified the criteria of patients to be reviewed. These were:

- New patient unbooked (Open Referral that is categorised as Urgent waiting over 12 weeks and six days before being booked.
- Two week wait first appointment wait over 21 days and are subsequently diagnosed with cancer
- Follow Up Unbooked Partial Booking Waiting List (PBWL) going over one Day - Time Critical
- 52-week waiters on an Incomplete Pathway

In addition, the trust had added mandatory actions for the clinicians to complete at the clinic appointment to the e-outcomes report forms for patients with open referrals greater than 12 weeks and patients who had been allocated time critical appointments that were overdue. Clinicians were also required to complete incident forms and harm review form for all patients where the level of harm was identified to be low, moderate or severe, which would then be reviewed at governance meetings.

We saw copies of letters that were to be sent to patients on the waiting list who were awaiting urgent appointments following their initial referral by their GP. Patients waiting over 12 weeks and over 24 weeks were to be sent letters to apologise for the delay. The letter asked patients to contact the trust’s Patient Advisory and Liaison Service (PALS) or their own GP if they believed their condition had deteriorated.

However, all of these actions were retrospective and we were not assured the trust was taking appropriate action to review and mitigate the harm to patients still currently on the waiting list.

Outpatient services had processes in place to record patient outcomes after each clinic appointment. The service used an electronic outcome form, which was intended for consultants to complete at the end of every appointment. The outcome form recorded whether the patient required another appointment, was to be referred to another service or discharged from the service.

When we inspected the outpatient service in October 2016, we found significant number of incomplete patients’ outcomes following appointments. At that time, there were 8,108 incomplete outcomes, with the oldest dating back to June 2016 (i.e. four months overdue). Following our inspection, the trust told us the plan was for the number of incomplete outcomes to fall by half in early 2017.

During this inspection, we saw all patient's records outcomes were recorded electronically, which was the responsibility of the lead clinician. Data provided by the trust showed as of March 2018 there were 6044 number of incomplete outcomes trust wide). The majority of the missing outcomes were for clinics held in February 2018 (3,800). However, there were 412 missing outcomes up to January 2018, the oldest dated back to clinics held in March 2017 (i.e. 12 months overdue). The top three specialities for missing outcomes was Dermatology (1042), ophthalmology (520) and urology (497). This meant patients might be at risk of staff not taking appropriate action regarding the care and treatment they needed.
Managers audited patient outcome results to identify which patients did not have an outcome recorded. We reviewed minutes of the trust wide ‘RTT Delivery and Recovery’ meeting where missing outcomes were discussed and missing outcomes by speciality were highlighted. Service leads told us it was the clinician’s responsibility to ensure patient outcomes were recorded, and the clinical specialities were held to account for missing outcomes. However, we were not assured this was a robust process in view of the number of outcomes that were missing and the length of time some had been outstanding.

Staff used the World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery for all minor procedures within outpatients, for example dermatology and we saw this process was audited regularly to ensure compliance. Staff working within cardiology told us the WHO checklist was being replaced by the DCIS checklist, which was more relevant to cardiology procedures.

Staff working within dermatology told us all instruments used for minor surgical procedures within the outpatient’s department were single use. There was a system in place to track and trace all instruments used which meant they could identify which instruments had been used for any patient. Therefore, staff could identify patients if concerns about instruments were identified at a later date.

Staff did not routinely use early warning scores within outpatient areas. However, outpatient services had clear processes for admitting clinically unwell patients to hospital. If a patient became unwell, during their attendance, staff escalated to senior nurses and medical staff were on hand to treat deteriorating patients immediately.

**Nurse staffing**

Staff we spoke with told us there were appropriate levels of staffing to meet the needs of the service.

There is no national baseline acuity tool for nurse staffing in outpatients. Individual business units for the clinical specialities funded the nurse staffing for the clinics they ran. The outpatients’ matron told us she was undertaking a workforce review of each clinic. This would be a more flexible approach to staffing and would assess the clinical competencies required for each clinic. It was hoped this would allow the service to appoint a clinical educator for outpatients.

We were told there were no vacancies for band five nurses or health care support workers but the trust would soon be advertising to fill the vacancy for an interim deputy sister to cover for maternity leave.

Staffing information was displayed on notice boards in one of the patient waiting areas. During the course of our inspection, actual staffing was mostly in line with required staffing. Senior nurses and the matron reviewed staffing levels weekly and discussed staffing arrangements with clinic staff during their morning ‘safety huddle’. All clinics had a daily huddle or team meetings to discuss staffing arrangements.

Some outpatient services had nurse-led clinics run by specialist nurses for example diabetes and urology clinics.

The trust reported their registered nursing staff numbers, as of October 2017, as shown below. For all sites there were 145.4 whole time equivalent (WTE) planned staff and 131.2 WTE staff in post as of October 2017.
The trust reported their health care support worker and support staff, as of October 2017, as shown below.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>75.7</td>
<td>73.1</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>42.1</td>
<td>33.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to October 2017 the trust reported a vacancy rate of 9.1% for nursing and midwifery staff in outpatients. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>11.5</td>
<td>5.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>11.5</td>
<td>15.1</td>
</tr>
</tbody>
</table>

Vacancy rates at Lincoln County Hospital were below the trust target, however at Pilgrim Hospital the vacancy rate was higher than the trust target of 11.5%. At the time of our inspection there was a zero-vacancy rate.

(Source: Routine Provider Information Request (RPIR) Vacancy)

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to October 2017 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 5.8% for nursing and midwifery staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust's turnover rate for nursing and midwifery staff is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>2.6</td>
<td>20.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>2.6</td>
<td>20.0</td>
<td>7.4</td>
</tr>
</tbody>
</table>

The turnover rate for both sites was within the trust's target of 20% for an individual staff group.

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

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
The trust reported sickness rates for medical staff within their own directorates.

From October 2016 to September 2017 United Lincolnshire Hospitals NHS Trust reported a sickness rate of 4.6% for nursing staff in outpatients. The trust’s target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Sickness rates for qualified nursing and health visiting staff from October 2016 to September 2017 were below the trust’s target at Lincoln County Hospital and above the target at Pilgrim Hospital.

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

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 2.9% with a further 0.3% of shift remaining unfilled. A breakdown by staff type and location is shown below:

**Pilgrim Hospital Boston**

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>0</td>
<td>194 (0.6%)</td>
<td>9 (0.0%)</td>
<td>33,643</td>
</tr>
<tr>
<td>Unregistered</td>
<td>0</td>
<td>1,140 (2.7%)</td>
<td>128 (0.3%)</td>
<td>42,740</td>
</tr>
</tbody>
</table>

The majority of shifts were filled by bank staff with only one shift in outpatients being filled by agency staff.

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As of October 2017, the trust reported a vacancy rate of 25.2% for medical and dental staff in outpatients. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>12.0</td>
<td>24.7</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>12.0</td>
<td>69.5</td>
</tr>
</tbody>
</table>

Vacancy rates at both Lincoln County Hospital and Pilgrim Hospital were higher than the trust target of 12.0%. The very high vacancy rate at Pilgrim Hospital is accounted for by the small numbers of staff at the hospital (there were 4.8 WTE vacancies at the hospital).
**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From November 2016 to October 2017 United Lincolnshire Hospital reported an annual turnover rate of 18.2% for medical and dental staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>2.8</td>
<td>20.0</td>
<td>20.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>0</td>
<td>20.0</td>
<td>0</td>
</tr>
</tbody>
</table>

The turnover rate for Pilgrim Hospital was below the trust’s voluntary target. Lincoln Hospital did not meet the trust’s target of a turnover rate of less than 20% for an individual staff group.

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

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From October 2016 to September 2017 United Lincolnshire Hospital reported a sickness rate of 0.2% for medical and dental staff in outpatients. The trust’s target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Sickness rates for medical and dental staff from October 2016 to September 2017 were below the trust’s target at both hospital sites.

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

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) Medical agency locum)

**Therapist staffing**

There were 294 whole time equivalent staff working trust wide within the therapy service, who provided outpatient, in-patient and community home based services.

Service leads told us of the difficulties recruiting staff for therapies particularly for Pilgrim Hospital including physiotherapists and occupational therapists. We were of a practice based learning
programme with a local university which had provided 15 each of physiotherapists and occupational therapists was drawing to a close. To mitigate this, the clinical lead for the service was leading a national ‘Trailblazer’ apprenticeship scheme, working with other local providers and local universities. (A ‘Trailblazer’ is a group of employers who work together to design new apprenticeship standards).

Records

The majority of medical records used within the trust were in paper format. Some records were available on-line, such as test results, diagnostic images, referral and clinic letters, however the main source of medical records were in hard copy, which were requested for clinic appointments. We saw staff used an electronic ordering and tracking system. We were told of future plans to move to electronic records, but this was unlikely to be within the next five years, because of other financial commitments.

When we last inspected the outpatient’s department in October 2016, we found there were significant issues with the availability of records for outpatient clinic appointments. We also highlighted the poor quality of some of the records and that the service did not store records in a way that protected patient confidentiality.

During this inspection we found some improvement in the availability of records. Trust wide audit data from September 2017 to January 2018 demonstrated 97.8% availability of health records for clinics for all specialities. This was an improvement from September 2016 which showed 89% availability. Service leads acknowledged this data included temporary records (4%) which were mostly due to appointments scheduled at short notice and notes in transit between sites.

The trust had a standard operating procedure (SOP) for the minimum data that was required in temporary notes. All notes were required to have as a minimum a copy of the referral letter, patient identifiable labels, blank history sheets, test results and the last clinic letter if applicable. We saw clinic staff had access to such essential information on-line.

During this inspection we saw there had been some improvement in the quality of records. We reviewed a copy of the trust’s Quality and Safety Improvement Plan which identified approximately 180,000 records across the trust which required merging or repair. The trust had created a ‘merge and repair’ project team. This was an additional 13 whole time equivalent staff employed for one year to repair damaged files and merge temporary and permanent notes. The trust had set a target of 23,500 notes to be repaired within the year from May 2017, and data provided by the trust during the course of our inspection showed that they were on target to exceed this trajectory. Service leads told us a business case was to be submitted for an additional two members of staff to continue the work when then ‘merge and repair’ project was completed.

During the course of this inspection we saw there had been some improvement in the storage of records. Medical secretaries did not feel they had sufficient storage space within their offices for notes, and we saw some cramped secretaries’ offices with limited storage space. We saw advanced plans to open a second medical records library within the hospital site which would double the current storage capacity and alleviate some storage issues.

Staff we spoke with were mixed in their opinion as to the improvements that had been made to medical records. Most staff agreed there was improvement in the availability of medical records, however the majority of staff, particularly within health records and medical secretaries, did not feel the quality of records had improved. We observed a large quantity of records that were still poor quality, very large or badly filed.
We saw that the some records were stored in a way that protected patient confidentiality. Patient records were stored in locked trolleys or within offices and manned reception areas. However, we visited the maxillofacial surgery area when the receptionist was away from the desk for a break. We saw the medical records storage cupboard door was wide open and all the medical records were accessible. We visited one of the oral surgery rooms where the door was standing open and saw a patient's medical records on the desk. There was no secure area for storage of notes within the ear, nose and throat (ENT) department; staff told us they had requested a keypad for the record storage room but this had been declined. There was a trolley of notes for a clinic in an unlocked room within the eye clinic. This meant there was a risk members of the public could access personal medical records if they wished to do so. We escalated all of these concerns to the nurses in charge.

Following our inspection visit, service leads provided a copy of the trust wide risk register for the choice, access and booking team and outpatients nursing. There were 44 risks on the register, of which 13 were categorised as 'extreme'. Of the 44 risks, 19 related in some way to health records and ten of these were classified as 'extreme'. Service leads told us that improving health records was one of the work streams in the outpatient improvement plan, which had been moved from project stage to 'business as usual'. However, the risk register had not been updated accordingly.

The trust audited the quality of documentation against the minimum standards set by the National Health Service Litigation Authority (NHSLA). This allows the trust to see where which areas are performing well and which have room for improvement. We reviewed the audit result for Pilgrim Hospital, for all specialities. The results highlighted there was 100% achievement in some but not all areas of audit, and the standard of documentation overall was not meeting the NHSLA standards. There were recommendations made for improvement for example developing a site action plan to improve areas of non-compliance.

We reviewed 20 sets of patient records. All records mostly contained the necessary information needed to plan and conduct care and treatment. Records contained care plans including any mental health or disability needs. Records contained letters to GPs and other relevant care providers. Most of the records met national guidance for record keeping. They were mostly legible, signed by doctors with the general medical council (GMC) number or contact number in them.

**Medicines**

The trust had a medicines policy, which was easily available to staff on the intranet.

We saw there was a robust procedure for storing and managing prescription pads.

Staff stored medicines in locked cupboards or fridges. Staff checked cupboards and fridges daily and recorded fridge temperatures. There were no controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001) stored within the general outpatient’s area, however we did see controlled drugs stored within other specialist outpatient areas, for example maxillofacial surgery. We saw the CDs were stored appropriately in a locked cupboard and the keys held separately from the main keys.

In December 2017, the trust identified that there was a lack of secure storage for medicines used in the outpatient consulting rooms. This was added to the risk register and at the time of our inspection secure medicines cabinets had been ordered for all consulting rooms trust wide. We
saw control measures had been introduced in the interim period to reduce the risk of unauthorised access to medicines.

We saw robust procedures for the management and control of medicines prescribed for individual patients, for example within ophthalmology.

**Incidents**

Staff reported incidents, accidents and near misses through the trust’s electronic reporting system. All staff we spoke with knew the process for reporting incidents using the trust electronic reporting system.

Staff discussed learning from incidents at team meetings and ‘time to talk’ safety huddles. Staff were able to describe serious incidents that had occurred and the learning that had been shared as a result. Staff were also able to describe ‘near-miss’ and low harm incidents that had occurred within the department, for example when the wrong patient identification label had been placed on a prescription chart.

However, some staff told us they would not always report missing or damaged records for patient appointments because they did not have time to do so.

**Never Events**

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

From January 2017 to December 2017, the trust reported no incidents classified as never events for outpatients.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with two (50% of total incidents)
- Confidential information leak/information governance breach meeting SI criteria with one (25% of total incidents)
- Pressure ulcer meeting SI criteria with one (25% of total incidents)
There were no serious incidents reported for Pilgrim Hospital.

(Source: NHS Improvement - STEIS (01/12/2016 - 30/12/2017)

**Duty of Candour**

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

Staff we spoke with knew about the duty of candour and the concepts of openness and transparency. Some gave examples of how they might apply the duty of candour when required.

**Safety thermometer**

The NHS safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. However, outpatient’s services did not participate in collecting data for the NHS safety thermometer.

Some safety information and performance was displayed some clinic areas including infection control, hand hygiene and patient feedback.

**Is the service effective?**

**Evidence-based care and treatment**

We saw evidence that patients’ physical, mental health and social needs were assessed, and their care, treatment and support delivered mostly in line with legislation, standards and evidence based guidance, including the National Institute of Health and Care Excellence (NICE).

Guidelines were easily accessible to staff on the trust’s electronic intranet. We reviewed 12 guidelines, all but two were in date and the version highlighted with mostly up to date references in
use. We saw the unstable angina guideline (STEMI) was overdue for review since February 2017 and the contrast nephropathy guideline had just passed the review date of 1st February 2018.

Outpatient services in conjunction with the clinical specialities participated in national benchmarking clinical audits such as the Sentinel Stroke National Audit programme (SSNAP), Heart Failure, the National Diabetes Inpatient Audit (NaDIA) and the national oxygen prescribing audit for patients with chronic obstructive pulmonary disease (COPD).

Occupational therapy staff worked to the Royal College of Physicians guidelines for the management of patients who had suffered a stroke. This was measured by the Sentinel Stroke National Audit programme (SSNAP), and we saw the trust had been graded ‘A’ in the previous quarter’s audit. In addition, occupational therapy staff were participating in a falls avoidance project which was in line with NICE guidance.

Physiotherapists we spoke with confirmed they worked to NICE guidance and received updates about new guidance being developed, for example in relation to tracheostomy guidance.

Staff told us of plans to commence an audit of local safety standards for invasive procedures (LocSSIPS). We were told this would include a five-step process with 20 random cases per consultant being audited.

Staff working in the deep vein thrombosis (DVT) (blood clots in the legs) clinic used a recognised clinical prediction model for patients, which is considered to be good practice and in line with latest evidence.

The chronic pain management service did not meet some of the criteria as advised by the Royal College of Anaesthetists, Faculty of Pain Medicine. For example, there was no psychologist input for patients or formal multi-disciplinary team meetings.

**Nutrition and hydration**

Staff had arrangements to provide food and drink for patients who were in the department for any length of time. We saw that jugs of water and squash were provided in clinic areas for patients and visitors. In the event of long waiting times, patients and visitors could bring in their own refreshments or buy hot drinks and light refreshments in the coffee shop located in the main waiting area.

We saw evidence in all clinics we visited staff were following the guidance NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. For example, staff in the diabetes clinic provided nutritional advice to patients in order to aid them manage their conditions.

**Pain relief**

Patients were not routinely assessed for pain in outpatients. We were told patients received local anaesthetic when undergoing minor procedures such as ophthalmology and maxillofacial surgery.

Staff discussed simple oral analgesia and its use for patients at home and gave advice when to seek guidance, but did not generally administer it unless it had been ordered for individual patient use. Patients were encouraged to take their own if required, for example within the fracture clinic.

**Patient outcomes**

**Follow-up to new rate**
From October 2016 to September 2017 the follow-up to new rate for all hospital sites was better than the England average.

**Follow-up to new rate, United Lincolnshire Hospitals NHS Trust.**

![Graph showing follow-up rates](image)

(Source: Hospital Episode Statistics)

**Competent staff**

Staff had the skills, knowledge and experience to identify and manage issues arising from patients’ mental health conditions, learning disability, autism and dementia. All staff received training to identify mental health and learning disability issues as part of their mandatory training.

Clinical nurse specialists ran some clinics and outpatient services. These nurses had achieved additional qualifications and competencies. For example, the nurse specialist within ear, nose and throat had additional qualification by taking a head and neck course, an ear care diploma and was an oral care practitioner.

Qualified nursing staff working within the different outpatient specialities had undertaken specialist training relevant to that speciality. For example, staff working in the DVT clinic had undergone training with a venous-thromboembolism (VTE) specialist and had completed competency documents.

Newly qualified physiotherapy and occupational therapy staff rotated between the specialities to get good experience of all aspects of the service.

Outpatient services recruited volunteers where required. Staff trained and supported volunteers for the role they undertook. Volunteers attended a full day induction training including, manual handling and fire safety. Volunteers we spoke with confirmed they had received this training.

**Appraisal rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust provided appraisal rates for staff who required an appraisal from April 2017 to October 2017. As most appraisals are carried out at the end of the financial year figures do not include all
staff members. From April 2017 to October 416 staff were required to complete an appraisal with 65.1% of these having received an appraisal. This was lower than the trust target of 85%.

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

At Pilgrim Hospital 112 outpatient staff were required to complete an appraisal with 71.4% of these having received an appraisal. This did not meet the trust target of 85%. 67.6% of qualified nursing and health visiting staff had completed.

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

All qualified nursing, therapy and health care support workers we spoke with confirmed they had received an appraisal within the past year. Data collected from the trust whilst on inspection demonstrated 96.4% of nurses and healthcare support workers and 95% of therapy staff had received an appraisal.
Multidisciplinary working

All necessary staff, including those in different teams and organisations were involved in assessing, planning and delivery care and treatment.

We saw evidence of good multidisciplinary (MDT) working across teams within the outpatient’s department. For example, we were given an example of staff working in partnership with other agencies in relation to a child who regularly attended the outpatients department. Staff told us of excellent communication with the multi-disciplinary team which included dieticians, GP and social services.

Staff told us of regular video conference MDT meetings with specialist staff at other sites within the trust and also with specialists at other trusts for example, within the urology and respiratory specialities.

Staff within dermatology had links with the child and adolescent mental health service (CAMHS) team and were able to communicate with them directly in relation to a patient identified as requiring ‘team around the child’ (TAC) support.

However, we were told there was no formal MDT meeting for staff working within the chronic pain management in line with RCA Faculty of Pain Medicine.

Seven-day services

Some outpatient specialities held additional ad hoc Saturday morning clinics to meet the increasing demand on the service, for example in ophthalmology, cardiology, nephrology, haematology, dermatology, respiratory and ear, nose and throat.

The eye clinic shared the on-call eye casualty service rota with staff from Lincoln County Hospital. Staff from Boston were usually rostered to cover the first and third week of the month.

Health records staff worked a variety of shifts to provide a 24-hour medical records service from Monday to Friday. Staff also provided a service from 06.00am to 10.00pm Saturdays and from 07.00am to 07.00pm on Sundays and bank holidays. Staff were able to access patients medical records at all other times by contacting the duty site manager.

Health promotion

During our inspection, we observed a range of literature, which supported healthy living choices for patients. A large proportion of these leaflets centred on having a healthy diet and sensible exercise regimes.

Therapies staff promoted mobility of patients following referrals to the fracture clinic and inpatient areas. Occupational therapists were participating in a falls avoidance project for frail elderly patients identified as at risk of falls.

We saw wall displays of patient information within the waiting area of the maxillofacial surgery department. These striking displays provided information the benefits of alcohol and sugar intake to oral health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Staff obtained written consent for operation. Verbal consent was obtained for other small procedures and tests which were documented in the medical records. Patients were given a leaflet called ‘about the consent form’ to ensure they understood the purpose of the consent form.

The trust had a consent policy which followed NHS guidelines. The Trust participated in the National Health Service Litigation authority (NHSLA) consent audit for both adults and children every six months. The trust reported these audits by speciality rather than as an outpatient’s department.

The Mental Capacity Act 2005 (MCA) is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them. Staff understood their roles and responsibilities regarding consent and decision making including the Mental Capacity Act 2005 (MCA).

For people over 16, the trust used the MCA; conducting capacity assessments when capacity was in doubt. We saw that guidelines and documentation were on the intranet for ease of reference.

Staff accepted parental consent for children under 16 years old, or, if the child was deemed to be competent, they could consent in their own right. To assist staff in assessing whether an under 16 has the capacity to consent, the trust had links on its intranet page to guidance relating to Gillick competence. (Gillick is a term used to describe if a child under 16 years of age is able to consent to their own medical treatment without the need for parental permission or knowledge.)

All clinical staff received MCA and consent training as part of the mandatory safeguarding training.

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

Deprivation of Liberty safeguards training at the trust is completed as part of the Mental Capacity Act (MCA) level 2 training module. The trust reported that from April 2017 to October 2017 MCA level 2 training had been completed by 84.1% of staff within outpatients. This was lower than the trust target of 90%.

The trust set a target of 90% for completion of MCA level 2 training. A breakdown of compliance for MCA level 2 training for medical and dental staff in outpatients from April 2017 to October 2017 is shown below:

A breakdown of compliance for MCA level 2 training for qualified nursing and health visiting staff in outpatients from April 2017 to October 2017 is shown below:

**Pilgrim Hospital – Qualified nursing & health visiting staff (Qualified nurses)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>45</td>
<td>41</td>
<td>91</td>
<td>90</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital the trust target was met by qualified nursing and health visiting staff (91.1%).
Pilgrim Hospital – Support to Doctors and Nursing Staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>37</td>
<td>32</td>
<td>86</td>
<td>90</td>
<td>No</td>
</tr>
</tbody>
</table>

At Pilgrim Hospital the trust target was not met by support to doctors and nursing staff. (86.4%).

**Is the service caring?**

**Compassionate care**

The NHS Friends and Family Test (FFT) gives every patient the opportunity to feed back on the quality of services. Data for outpatient services at the Pilgrim Hospital for January 2018 showed 93% of patients would recommend the service to others. The number of patients who responded to the survey was 1291, which was a response rate of 9%.

During our inspection, we spoke with 27 patients and their relatives. All patients were positive about the staff. Comments included; “the doctor was really nice to me”, “I would recommend this hospital, the people know their job so I just sit back”.

Staff ensured patients’ privacy and dignity where ever possible. We observed staff closing doors and using curtains in the majority of clinical areas when talking to or examining patients. However, we observed that staff working in phlebotomy (blood tests) did not close the curtains when taking patients into cubicles for their blood tests. We observed other staff, including administrative staff, walking in and out of the cubicles to ask the phlebotomists questions whilst patients were having their tests. Some ophthalmology patients had some assessments carried out in a corridor before receiving treatment in another room. Staff attempted to maintain patients’ dignity by the use of a curtain screen but acknowledged this was not an ideal situation caused by a lack of clinical rooms. This was on the risk register.

Staff told us they offered chaperones, especially for intimate procedures or personal advice. We saw clinic rooms and waiting areas displayed posters offering patients chaperones. Staff told us the chaperone service was not compromised, even when staffing was low. Patients confirmed when they had asked for a chaperone, one had been made available.

The service used volunteers to support and help guide them around the hospital. Volunteers were based in the main outpatients entrance and we observed them to be smiling and friendly to patients and carers, offering directions to clinics and general reassurance.

**Emotional support**

We saw nursing staff comforting a distressed patient. We observed the staff members quickly moved the patient into a counselling room to provide additional support.

Staff within the breast care unit were able to provide additional support for patients. For example, for patients who had received bad news counselling was available either the same day or the next day. Staff could also offer referral to a dedicated clinical psychotherapist.

Staff at the breast care unit used a distress ‘thermometer’ which allowed patients to describe how much distress in general they had been experiencing in the previous week. Patients who scored highly were referred to the clinical psychotherapist.
Understanding and involvement of patients and those close to them

Staff mostly involved patients and those close to them in decisions about their care and treatment. The majority of patients and relatives we spoke with in the outpatients department said that they felt involved in decisions about their or their loved ones care and treatment. However, two of the 27 patients we spoke with told us they did not understand what would be happening to them in the next stage of their care.

A patient we spoke with told us about advice and support given by staff within the breast care unit. She told us of the advice she had been given relating to swimwear and underwear. The Pilgrim Hospital laundry staff offered a free service to sew bras for cancer patients to meet patients’ measurements if required. The patients valued the service as specialist bras can be costly to buy and not all patients can afford to buy specialist underwear.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The main outpatients department at Pilgrim Hospital was accessible from its own dedicated entrance or by walking through the hospital. In addition, the outpatient therapy service also had a dedicated entrance or could be accessed through the outpatients department. The hospital delivered services to patients on one floor. Therefore patients were not required to use the lifts or stairs, and made services accessible to all patients, including those with disabilities.

Car parking for all patients was situated closed to the outpatients department. We saw there were wheelchairs available outside the department for patient use, however reception staff we spoke with shared concerns there were too few wheelchairs for the amount of patients and had received complaints from patients when they were unavailable.

We found the general signposting for outpatients clear. There were also three lines painted on an internal wall which directed patients from outpatients to pathology and the accident and emergency department. This meant patients could find their way back to outpatients from these departments. However, these lines did not extend to the main hospital entrance. The lines were thin and located high on the wall, which meant they might not be accessible for visually impaired patients or wheelchair users.

Patients were able to book in at main reception either using one of the two electronic touch screen devices, or by booking in at one of four reception desks. These devices were enabled to allow use by sensory impaired patients.

There was a main patient waiting area, which included a coffee shop, and several smaller sub waiting areas, some of which had their own receptionists. Some of the sub waiting areas were small and cramped, and we saw patients were directed to wait in the main waiting area and were then called through for their appointments.

A variety of chairs were provided in the waiting areas, including those that were larger and had high backs and low seats, in order to provide appropriate seating for all patients.

The trust had installed large visual display screens that displayed patients’ names when they were being called for their appointment. There was one screen on either side of the large main waiting area. Not all patients would be able to see the screen from all parts of the waiting area; however,
the screen made a loud audible noise to alert patients’ attention to the screens. Staff told us and we observed clinic staff coming to the main waiting area to call patients for their appointments if they were unaware it was their turn.

Senior nursing staff had undertaken the '15 steps challenge' of the outpatients department, which focuses on seeing the care environment through a patient’s eyes and within the first 15 steps into the environment. Following that review staff had made small changes to the ear, nose and throat (ENT) reception area to make a better impression for patients.

Some staff did not have dedicated areas to change or have breaks. Storage in some of the medical secretaries offices was very limited and some clinical areas did not have dedicated storage areas for medical records.

Clinical specialities provided some ‘one stop shop’ appointments. For example, within dermatology potentially cancerous skin lesions could be removed at the initial clinic appointment if possible to avoid further growth of the cancer and save the patient returning to clinic. However, this did mean sometimes slightly longer waiting times for patients during the clinic. The ‘one stop shop’ for suspected respiratory cancer included the physiology department, lung function tests and diagnostic imaging all held on a Thursday morning. Patients with urgent referrals to the vascular service were also able to have investigations and consultation on the same day.

Satellite clinics for some specialities, for example respiratory, well held at other locations including Grantham, Skegness and Spalding. This meant some patients were able to access outpatient clinics within their local area.

The cardiology speciality offered a range of outpatient services and investigations including echocardiogram (a scan of the heart and blood vessels), stress electrocardiogram (ECG) (to see how the heart responds to exercise), 24-hour heart monitoring, perfusion scans (looking at blood flow to the heart), and tilt testing (to find the cause of fainting).

The trust provided outpatient services for occupational therapy, physiotherapy, dietetics (diet and the effects on health) and orthotics (surgical appliances). A local community health NHS trust provided podiatry and speech and language services.

Joint working arrangements with partner organisations did not always ensure good experience for patients. Patients sometimes waited a long time for transport from an external company to arrive to take them home after outpatients. Staff and patients both said long waits for patient transport were an issue and staff gave examples of patients waiting several hours for transport to arrive. Staff told us they reported any patient transport delays through their incident reporting system. Service leads were monitoring delays and were in discussion with the external company.

Did not attend rate

The service sent text messages to patients one week before the appointment to remind them of their appointment date and time and to help reduce the number of patients who did not attend. We spoke with patients who confirmed they received these messages.

From October 2016 to September 2017 the ‘did not attend’ rate for Lincoln County Hospital was lower than the England average and the ‘did not attend’ rate for Pilgrim Hospital was similar to the England average.

The chart below shows the ‘did not attend’ rate over time.
Meeting people’s individual needs

There was an ongoing refurbishment of the main patient waiting area at the time of our inspection. Following the refurbishment, a quiet room would be available for patients. This would be especially useful for patients with complex needs who find noisy environments challenging.

Staff within dermatology were aware of, and made adjustments for, patients with mental health or other complex needs. They organised for patients to see the same clinician wherever possible in order to maintain the patient’s routine and reduce anxiety.

Staff told us if they had identified a patient was becoming anxious or agitated whilst they were waiting, they would attempt to get them quickly in to their clinic appointment wherever possible.

Staff told us they used telephone translation service when required for patients where English was not their first language. Other frequently spoken languages were mostly eastern European, mainly Russian and Latvian. Nursing staff told us they did not use patients or other staff as translators, in line with trust policy. There were high numbers of deaf patients within the ear, nose and throat speciality. Staff told us it was common for sign language interpreters to be arranged for patients.

In the spring of 2017, a national access information provider audited all clinical areas of the trust, including the outpatients department, to assess accessibility for disabled patients. Accessibility information was available from both the trust’s website and the independent provider’s website. Feedback from this independent audit was being included in the trust’s estates strategy.

There had been additional access improvements including an ongoing audit of hearing loop provision and all the self-check-in kiosks within the outpatients departments were sensory impairment enabled. In addition, the trust told us they were establishing additional engagement with service user groups.

Staff working within the breast unit undertook mandatory end of life care training and had strong links with specialist cancer charities. Staff ran support groups for patients. Female patients who were aged under 45 were seen in a specialised clinic and were offered a network of support. Staff also worked closely with residential care homes for more elderly patients.
Health passports were completed for any vulnerable adult including those with learning disabilities, mental health needs or patients living with dementia. Dementia champions were available and could be contacted to assist and support patients and carers patient/care/supported with dementia passport.

There was no flagging system within the patient records to identify patients with complex needs or living in vulnerable circumstance. However, staff we spoke with demonstrated they were able to provide appropriate support for such patients. For example, staff working within the fracture clinic told us they used the patient history and worked in liaison with the emergency department to identify patients' additional needs. They were able to speak to the crisis team for patients having an acute mental health episode, dementia champions and the independent living team; an on-call outreach team who assisted with access to the voluntary services and social care support.

The eye clinic had recently appointed a liaison officer who provided support to the eye clinic and any patients requiring assistance following blind or partial sight registration. This meant patients had good access to support services and reported monthly to a leading charity.

**Access and flow**

Staff using electronic booking systems offered patients a choice of appointments. Other health professionals, such as GPs, referred most patients through the electronic referral system, and given options of dates and times for their appointments. Some referrals were received by letter or fax.

Clinics used a mixture of partial booking and full booking processes for follow up appointments. This was dependent upon the specialty and needs of patients. Partial booking is a system which provides patients with a target date for the next appointment. Staff contacted patients nearer the time of the target date to arrange the exact date and time. Full booking meant staff gave patients a date and time for their appointment and this was usually for appointments that were required within six weeks. Partial booking reduced the risk of cancelling appointments because staff could take into account future demand for urgent appointments or other factors such as consultant leave.

When we inspected the outpatient service in October 2016, we found significant number of patients were overdue appointments on the partial booking system. Following this inspection, the trust provided data relating to the number of patients waiting for a follow up appointment and we noted some improvement. As of 19 March 2018, there were 5,964 patients on the partial booking waiting list (compared to 7,483 in October 2016). Of these 3,333 patients had been waiting more than 6 weeks beyond the target appointment date (compared to 3772 in October 2016). In total there were three patients waiting more than 52 weeks, 71 patients waiting 40 to 52 weeks, 487 patients waiting 26 to 40 weeks, 1358 patients waiting 13 to 26 weeks and 1414 patients waiting between six and 26 weeks beyond their target appointment date.

Staff told us there were major capacity issues within dermatology with patient backlogs from November 2018. This was as a result of staffing issues resulting from long term sickness

Service leads told us of changes to levels of treatment within primary care which had led to increased referrals and subsequent longer waiting times. For example, within ENT, GP surgeries were no longer providing ear syringing and were being referred to the trust. The backlog was being tackled by removing administration tasks from clinical nurse specialists to allow for additional clinical sessions.
From a review of clinical speciality meeting minutes, we saw staff discussed the waiting lists. These discussions included additional clinics where possible and a review of the utilisation of theatres. During our site visit, staff told us extra Saturday morning clinics had been put on to help manage waiting times within the specialities of cardiology, nephrology, haematology, dermatology, respiratory and ENT. These clinics were for both new and follow up appointments.

The trust supplied data in relation to the number of clinics cancelled. There were 29 clinics cancelled from the 1st to the 7th of March 2018 across the trust. The majority of clinics were cancelled with long periods of notice given, i.e. over six weeks. There were seven clinics that were cancelled with less than six weeks’ notice and the reasons listed were ‘other’.

Data provided by the trust for the period April 2017 to February 2018 showed the average proportion of new appointments to follow-up appointments was 1 to 1.48.

The podiatry service recently appointed an additional consultant. They introduced a system whereby consultants reviewed and prioritised all new referrals and allocated to clinics accordingly. This meant the waiting time for appointments patients with infected leg ulcers was less than two weeks, which was in line with National Institute of Health and Care Excellence (NICE) guidelines.

Some of the patients we spoke with told us they given no information that the clinics were not running to time. However, during our inspection we heard several staff making announcements and giving apologies about the late running of clinics. Staff told us they tried to be honest with patients about potential waiting times within clinics. For example, in the ENT clinic, staff suggested to patients they leave their mobile number and go off to the coffee shop for a drink whilst they were waiting for their clinic appointment.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From November 2016 to September 2017 the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance.

From November 2016 to July 2017 the trust’s performance was between 5% to 8% worse than the England overall performance, with the percentage of patients treated within 18 weeks ranging from 82.1% and 85.0%. However, there was an improvement in performance for August 2017 (87.1%) and September 2017 (85.8%) which was closer to the England overall performance (2.4% and 3.3% below the England performance respectively).

In October 2017 (and November 2017) the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, United Lincolnshire Hospitals NHS Trust.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

From November 2016 to September 2017 two specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>95.3%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>94.7%</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

From November 2016 to September 2017 14 specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>52.8%</td>
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<tr>
<td>Cardiology</td>
<td>68.9%</td>
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<tr>
<td>Rheumatology</td>
<td>76.3%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>77.1%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>78.1%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>80.6%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>82.3%</td>
<td>89.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>84.7%</td>
<td>89.7%</td>
</tr>
<tr>
<td>Other</td>
<td>85.1%</td>
<td>91.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>85.2%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>85.7%</td>
<td>90.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>85.8%</td>
<td>95.6%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>86.4%</td>
<td>92.6%</td>
</tr>
<tr>
<td>Urology</td>
<td>87.6%</td>
<td>88.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From November 2016 to September 2017 the trust’s referral to treatment time (RTT) for incomplete pathways has been similar to the England overall. From December 2016 to April 2017 the trust’s performance was slightly below the England performance by between 1% and 1.7%. From May to September 2017 the trust performed 0.1% to 0.7% below the England average. Over the time period the trust’s overall performance ranged from 88.1% to 89.9%

In October 2017 (and November 2017) the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.
Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, United Lincolnshire Hospitals NHS Trust.

(Source: NHS England)

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

From November 2016 to September 2017 four specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>96.1%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>95.0%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>93.0%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>86.4%</td>
<td>84.6%</td>
</tr>
</tbody>
</table>

From November 2016 to September 2017 12 specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>74.3%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>78.2%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>81.1%</td>
<td>91.5%</td>
</tr>
<tr>
<td>ENT</td>
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<td>Thoracic Medicine</td>
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<td>Geriatric Medicine</td>
<td>96.4%</td>
<td>96.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral. For the most recent quarter (2017/18 Q2) only 87.5% of patients
were seen by a specialist within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

**Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), United Lincolnshire Hospitals NHS Trust**

![Graph](image)

*Source: NHS England – Cancer Waits*

**Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)**

The trust is performing similar to the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). For the most recent quarter (2017/18 Q2) 96.4% of patients waited less than 31 days from diagnosis to first definitive treatment. The performance over time is shown in the graph below.

**Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), United Lincolnshire Hospitals NHS Trust**

![Graph](image)

*Source: NHS England – Cancer Waits*

**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

The trust is performing below the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. For the most recent quarter (2017/18 Q2) 69.0% of patients waited less than 62 days from urgent GP referral to definitive treatment. The performance over time is shown in the graph below. Updated dated at the time of our inspection showed performance was 75.6% for Q4.
Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, United Lincolnshire Hospitals NHS Trust

![Graph showing percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment.](image)

(Source: NHS England – Cancer Waits)

Learning from complaints and concerns

There were Patient Advisory and Liaison Service (PA LS) leaflets in the outpatient departments, detailing how to make a complaint. Senior nursing staff were able to provide example of learning from complaints. For example, the training of staff in relation to immobile patients cared for the in the fracture clinic. Staff said managers shared learning from complaints through briefings and team meetings.

Summary of complaints

From October 2016 to September 2017 there were 79 complaints about outpatient care. The trust took an average of 69 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 79 complaints, 62 had been closed at the time the data was provided and only 6.5% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days. Even when taking this target into consideration still only 21.0% of all of the closed complaints were closed within 50 days.

At Pilgrim Hospital there were 34 complaints. The trust took an average of 68 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 34 complaints, 24 had been closed at the time the data was provided and only 3.6% of these had been closed within 35 days. The trust has a further target to close 80% complex complaints within 50 days. Even when taking this target into consideration still only 21.4% of all of the closed complaints were closed within 50 days.

There were five complaints that were re-opened in the time period.

Many of the complaints had more than one theme. The most common themes complained about at Pilgrim Hospital were the wait time to get an appointment (nine), attitude of staff (five), failure to diagnose (three) and access to orthotics (three). There were also seven complaints that related to the communication with the patient.

(Source: Routine Provider Information Request (RPIR) Complaints)
Is the service well-led?

Leadership

At the time of our last inspection in 2016, the management of outpatients’ services was being restructured. At this inspection we saw the new management structure was fully embedded. Administration staff from health records and the access, booking and choice team were managed together with the outpatients nursing and reception staff as part of the pan trust Clinical Support Services (CSS) Business Unit. CSS included five clinical teams including therapies and rehabilitation, diagnostics, radiology, breast screening and pharmacy and was also responsible for the administrative teams for health records, booking and choice and reception.

A Clinical Director, who was supported by four clinical leads, led the CSS business unit. In addition, there was a general manager and three matrons, some of whom had pan trust responsibilities. The clinical director reported to the chief operating officer (COO).

The general manager was line managed by the trust’s head of operations and from whom they would receive appraisals and monthly one to one meetings. However, during our inspection in February 2018, we saw the general manager had not received a one to one since November 2017. We were also concerned the general manager did not have sufficient capacity to manage the workload. Other divisions had a quality and safety officer, who would support the general manager; however, this role was missing from CSS. Service leads acknowledged a lack of administrative resources within the division. They told us of plans to appoint an individual to this role in the near future. This would be a band six, full time post.

The trust developed an outpatient matron structure (for Lincoln and Louth; Boston and Grantham) which incorporated a substantive structure for nursing roles, this provided greater managerial coordination and flexibility to increase and decrease service capacity within all hospital sites.

The leadership team had full appreciation of the challenges to quality and sustainability and were active in identifying and implementing the actions needed to address them. Each member of the senior management team within the business unit worked on one of the seven service improvement work streams. At present the service could not be fully assured that the improvements made were sustainable. Continued oversight was required to ensure the changes became ‘business as usual’.

Staff were mixed in their views of senior leaders. Some staff said senior leaders in the trust were not as visible as they might be. Most of the staff we spoke with knew the names of senior management, but not all knew their faces and the majority said they had not been to visit their areas. Staff were also mixed in their views of local leadership across the organisation. Generally, nursing staff reported clinic sisters and matrons were visible and provided a good level of support. We observed matrons out in the clinic areas during this inspection.

The majority of administration staff we spoke with did not feel supported by their managers, particularly within health records and medical secretaries.

Vision and strategy

The trust developed new vision and values which were included as part of an extended communications campaign of the trust’s new 2021 strategy roadmap. This campaign was launched in late November and included engagement events, with a new visible brand for the trust, and live twitter and Facebook events with staff.
To ensure values and vision were embedded the trust also launched a staff charter and personal responsibility framework. These went hand-in-hand with their 2021 strategy and help to deliver their vision, values and ambitions.

The personal responsibility framework gave examples of the behaviours the trust would wish to see and those they would not wish to see, to help create a positive, caring working environment.

During the CQC inspection in 2016, the trust was in the process of developing an outpatient improvement programme. The programme included seven work streams focusing on health records, the outpatient environment, workforce development, improvements and innovation, safety culture and engagement, constitutional standards and clinical productivity and outcomes.

The trust implemented an outpatient transformation programme in April 2016. When we inspected in October 2016 we found progress was slow and key targets and milestones were not being met.

During this inspection we saw the formation of an outpatient improvement committee, with the COO as executive lead. An outpatient improvement plan was devised which had seven primary work streams. These included improving health records, workforce development, improving the workplace environment for patients (estates), improvement and innovation, improving safety and culture, clinical directorates’ performance and constitutional standards. (Constitutional standards are set out in the NHS operating framework and NHS constitution and give rules and definitions for patient waiting times to be seen by consultants and for treatment.) The primary work streams were further divided into 40 sub work streams. We were told the responsibility for the work stream relating to the environment sat with estates. Four of the work streams had been assessed as no longer in the project stage and were now ‘business as usual’. These included improving health records, workforce development, improvement and innovation and improving safety and culture. Whilst there had been some improvement in health record availability, we saw and staff told us there was still more work to be done around the quality of records and there was risk the pace of improvement would slow if this was considered ‘business as usual’.

Culture

The majority of clinical staff we spoke with said they felt supported and respected. All staff said they were proud to work as part of the trust and they spoke positively and passionately about the care they provided to patients.

We spoke to a significant number of staff who worked within health records. The majority of staff we spoke with described a bullying culture which was historical and ongoing, and some staff were able to give specific examples of when inappropriate language had been used. Comments made by staff to us included “ruling by fear”, “it’s always been like this” and “it’s a very strange department”. We spoke with local managers during the inspection, who told us they were unaware of any historic concerns. However, we saw evidence that showed that concerns about the culture had been shared with the managers within the past year. We escalated our concerns about the culture to service leads who attempted to engage with staff within that department, however staff told us the engagement was not effective and did not allay their fears. Service leads acknowledged there was more work to be done within that department.

Medical secretaries also described an unsupportive culture. Staff told us they did not feel able to escalate concerns relating to patients or issues with their managers.

Nursing staff within the main outpatients department described an improved culture following engagement work by the matrons.

The trust had an appointed ‘Freedom to Speak up Guardian’ who ensured that policies were in place and that staff knew who to contact if they had a concern. Staff we spoke with were not
aware of the existence of the guardian. Staff working clinically told us they felt listened to and felt empowered to raise concerns. However, administration staff did not feel able to raise concerns. One member of staff told us “we don’t feel we have anywhere we can go”.

Service leads told us they were implementing dignity ambassadors and had recruited staff volunteers for the role.

**Governance**

During our last inspection in October 2016, we found the governance arrangements and accountabilities for managing performance were unclear. During this inspection, we saw there had been an improvement in the governance arrangements particularly within specialty specific matters and performance measures. Directorate quality and safety officers examined waiting list reports and reported to the directorate governance groups. At the time of our inspection, the outcome from these meetings was not always embedded into practice or shared with the executive team, and clinical staff were not aware of or involved in the process. This may have been due to the infancy of the process.

Due to the single business unit managers described an improved co-ordination within the governance structure and greater interaction throughout the service.

Staff told us some arrangements with partners within primary care were difficult to manage and did not always promote co-ordinated person-centred care, for example within ophthalmology services. Patient centred care was promoted within services supplied by the local community trust.

The referral to treatment (RTT) recovery group met fortnightly and discussed harm reviews, clinical letter backlog, partial booking waiting lists, recruitment and missing patient outcomes. A recent six-week programme to include monitoring and managing patient outcomes improved clinician’s awareness. The trust reported backlogs to NHSI and the local clinical commissioning group.

**Management of risk, issues and performance**

Service leads had access to a wide range of information and data by means of a daily dashboard and a monthly scorecard. Data was linked to the outpatient improvement plan work streams, which we reviewed during the course of our inspection.

We reviewed the monthly scorecard which showed data from September 2017 to January 2018. The scorecard was colour coded green or red to show targets had been met (green) or not met (red). Of the five months for which figures were available, one was green, the remainder were red. The forecasted figure for January 2018 for patients overdue by more than six weeks on the partial booking waiting list (PBWL) was 2,379. The actual figure was 5,642 (therefore red) a variance of 3,263. Figures for the constitutional standards, which included referral to treatment data, patient outcomes and cancer performance was almost entirely red, which meant the trust had not achieved any of the forecasted targets for the five months of data.

Managers within the service were aware of the impact of not only winter pressures, but also the summer and university academic year impact on the service. However, we did not see any changes in readiness for these times.

However, the trust had met forecasted figures for health record availability, record merging and destruction and did not attend (DNA) rates for outpatient appointments.

A comprehensive recovery plan was in place to manage RTT performance however, slippage had occurred, and there were risks that revised trajectories would not be met. Previous trajectories to address referral to treatment times and waiting list backlogs were not met and had to be
readressed in February. We were not assured the recovery plans made to address the backlog were embedded or sustainable.

Service leads monitored and discussed performance at the ‘RTT and Recovery’ meeting, which included representatives from the individual specialities. We were told it was compulsory for all specialities to attend to discuss their own performance, however the minutes of the meeting from February 2018 show two specialities (head and neck and surgery) were not represented and were therefore not able to report and discuss their performance.

Commissioners and external stakeholders within the wider health economy had raised concerns about the improvement and sustainability of the service, particularly in relation to the cancer two week wait and 62-day breast pathway. They were working with the trust to take remedial action to mitigate further deterioration of the breast service amid concerns of poor performance for the next winter period.

Following our site visit, service leads provided a copy of the pan trust risk register for CSS. The trust used a scoring system for all risks on the register and allocated a category based on the score. The highest risks scored 20, and the lowest score was one. Categories were colour coded as a visual aid for staff. However, the colour coding was confusing, for some risks scoring 15 were categorised as ‘extreme’, whilst others also scoring 15 were categorised as ‘high’. Similarly, some risks scoring six were marked as either ‘low’ or ‘moderate’

There were 44 risks on the register which were either for ‘choice, access and booking’ or ‘outpatient nursing’, of which 13 risks were categorised, although not necessarily coloured, as ‘extreme’. The oldest risk on the register was added in April 2005, whilst the oldest ‘extreme’ risk on the register was added in January 2007. Middle management staff we spoke had a good understanding of the risks within their own area. For some of the ‘extreme’ risks there was little evidence of regular oversight recorded within the register and some items did not have any actions recorded to mitigate the risk. We were told that risk was discussed at the monthly governance meetings.

Of the 44 risks, 19 related in some way to health records and ten of these were classified as ‘extreme’, although it was not clear whether these risks were trust wide or location specific. Service leads told us that improving health records was one of the work streams in the outpatient improvement plan, which had been moved from project stage to ‘business as usual’. However, the risk register had not been updated accordingly. Therefore, we did not have assurance there was sufficient oversight of the risks recorded on the risk register. Service leads acknowledged the lack of administrative resources within the division and the quality and safety officer that was to be appointed would fulfil this role.

We saw senior staff within the clinical outpatients environment completed the ‘clinic leader assurance document’. This was a daily check by the senior nursing staff who signed to say that the department was safe, caring and well-led this was to give assurance of safety and wellbeing of patients and staff. This included an assessment of safe staffing, cleanliness, security and storage of medicines, availability of patient records, checking of emergency equipment and availability of chaperones. Senior staff were also required to talk to three patients about their experience, check the information boards were clear and up to date and the electronic patient calling boards were switched on. It was also a requirement that vulnerable patients had been identified and adequate provision for their care was in place for example patients with learning disabilities, living with dementia, identified safeguarding needs etc.

Service leads were working with an external financial company on a programme of work for the outpatients service. We saw a copy of the financial recovery programme for 2017/18 which
included milestones for achievement. We saw evidence where environmental changes and the implementation of electronic records was compromised by the financial pressures on the service.

There is a requirement for all organisations providing NHS funded care to implement national and local safety standards for invasive procedures (NatSSIPS and LocSSIPS). These evidence based standards are applicable to invasive procedures carried out within the outpatients department. Nursing staff we spoke with were unfamiliar with the term however we saw LocSSIPS had been implemented and were available online, for example for certain cardiac procedures however these had been awaiting approval from the patient safety committee since October 2017. This meant staff were using standards that had not passed governance processes to ensure their safety and appropriateness.

**Information management**

The data quality assurance group was reconvened to monitor data quality trust wide. This supported the newly implemented and upgraded electronic systems in use. Senior managers told us this gave greater awareness of patient waiting times and attendances.

The data from the electronic systems populated the scorecard measured monitored at the fortnightly meetings.

The patient outcome backlogs remained and had an impact on the quality of data staff worked with on a day-to-day basis. In addition, a delay in the writing of clinical letter had an impact on information sharing with other care providers. This was identified within one of the work streams and on the risk register.

Patient record quality remained a concern of the trust with 19 out of 44 risks on the risk register relating in some way to health records.

There were sufficient amounts of computer terminals to enable staff to access the trust’s intranet and the external internet.

GPs made referrals into the trust using an electronic referral system.

**Engagement**

As part of the recovery and transformation plan, the trust engaged with many external stakeholders in support of specialty pathway reviews. Working groups were held with the clinical commissioning group and the trust worked alongside primary care providers to support improved performance outcomes.

Outpatient services used the NHS Friends and Family Test (FFT) to seek patient views about whether they would recommend the service to others. Data for outpatient services at the hospital for January 2018 showed 93% of patients would recommend the service to others. The number of patients who responded to the survey was 1291, which was a response rate of 9%. Patients were asked to give feedback by text. Staff told us patients did not always respond to the texts as the number was not displayed on the patient’s phone.

We saw a ‘patient experience board’ in the outpatient department. The board highlighted areas of positive feedback the department had received and the comments included “caring”, “helpful”, “excellent”, “efficient” and “professional”. Negative comments were also listed and included “environment”, “late running clinics” and “too much waiting”. Improvements were highlighted, for example the refurbishment of the waiting area, the installation of patient call screens and volunteers on duty within the department.
Therapies staff conducted annual patient surveys. The results for January 2018 were that 96% of patients responded positively about the service, with a 30% response rate.

Outpatients department received three nominations for Clinical Team of the Year award as part of the trust’s award process, the sister was nominated for the outstanding leader and health records nominated for the non-clinical team of the year.

Senior staff told us of work to improve staff engagement and culture within the outpatients nursing team. We saw a ‘staff expectation card’ that had been devised with staff input and which was aligned with the outpatients nursing team objectives. The cards were used in conjunction with peer support training to tackle bullying and unsupportive behaviour within the department. Staff we spoke with within the outpatients nursing teams had received the training and agreed it had been useful and had improved the working culture.

Patient experience group representatives had been asked to join the outpatient improvement group.

The 2017 national NHS staff survey was published at the time of our inspection. Generally, the results across the NHS were poorer in 2017 than in the previous year. However, for most of the questions in the survey, the United Lincolnshire Hospitals Trust (ULHT) score had declined more sharply. The trust identified a number of themes from the data and the free-text answers to some questions. Overall, the results demonstrate a decline in staff morale, which was not unexpected by the trust. The response rate of 45% was above the England average and encouraging for the trust that staff wanted to engage. Of the respondents, 45% would recommend ULHT as a place to work, worse than the England average of 60%.

Twelve themes were extracted from the survey with action plans around staff engagement, the new strategy and the current workforce programme.

Learning, continuous improvement and innovation

The outpatient improvement programme focused on continuous learning, improvement and innovation.

Outpatient managers implemented capacity and demand models to improve services for patients such as the 6-4-2 clinic room availability model to reduce waiting times.

Advice and guidance services were available within ENT, haematology and cardiology, providing secondary care support to GP practices prior to referrals being made into the trust. This supported a more cohesive service for patients.

The ongoing refurbishment of the main waiting area within the outpatients department was designed to improve the patient experience. We saw the trust had installed patient call screens and a quiet area was being created for patients with complex needs.

Staff within health records displayed posters and organised open days to educate all trust staff around the accurate tracking of health records. This ensured all staff were aware of their responsibilities for patient records and reduced the amount of records that were unavailable for clinic appointments.

The outpatients department was developing a form of hourly rounding as part of a quality improvement project. Hourly rounding is a structured process where nurses carry out regular
checks on patients at set intervals. It was planned for staff to carry out checks on patients waiting within the department to ensure their nutritional, mobility and toileting needs were met.

The clinical lead for therapy service was leading a national ‘Trailblazer’ apprenticeship scheme, working with other local providers and local universities. (A ‘Trailblazer’ is a group of employers who work together to design new apprenticeship standards).

The Pilgrim Hospital laundry staff offered a free service to sew bras for cancer patients to meet patients’ measurements if required.
Medical care (including older people’s care)

Facts and data about this service

Medical services involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. The medical care service at United Lincolnshire Hospitals NHS Trust (ULHT) provides care and treatment for rehabilitation, complex needs medicine (elderly), cardiology, respiratory medicine, gastroenterology, general medicine, stroke rehabilitation, clinical haematology, clinical oncology and geriatric medicine.

There are 495 medical inpatient beds located across 24 wards at three locations in the trust: Lincoln County Hospital, Pilgrim Hospital Boston, and Grantham and District Hospital (GDH). At GDH there are 44 inpatient beds located within three wards: the Acute Care Unit (ACU), Ward 1 and Ward 6. In addition, medical services are provided in an emergency assessment unit (EAU) for the assessment and admission of acutely ill patients, a day care unit (DCU), and endoscopy unit. As part of our inspection we visited Ward 1, Ward 6, ACU, DCU, EAU, and the discharge unit. We also visited Ward 2, a surgical ward, where medical patients were placed, due to a shortage of medical beds.

From October 2016 to September 2017 the trust had 70,960 medical admissions. Emergency admissions accounted for 31,481 (44%), 37,660 (53%) were day case, and the remaining 1,819 (3%) were elective. Following our inspection, we asked the trust for a breakdown of medical admissions per hospital site, however this was not available.

Admissions for the top three medical specialties across the trust were:

- General medicine, 27,484
- Clinical oncology (previously radiotherapy), 8,005
- Gastroenterology, 7,941
Is the service safe?

Mandatory training

The trust set a target of between 90 to 100% for completion of mandatory training. A breakdown of compliance for mandatory courses at GDH from April 2017 to October 2017 for medical/dental and nursing staff in medicine is shown below:

Grantham Hospital – medical/dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>13</td>
<td>14</td>
<td>93%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>12</td>
<td>14</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>12</td>
<td>14</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>12</td>
<td>14</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>12</td>
<td>14</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>11</td>
<td>14</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>11</td>
<td>14</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>10</td>
<td>14</td>
<td>71%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>9</td>
<td>14</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>6</td>
<td>14</td>
<td>43%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>5</td>
<td>14</td>
<td>36%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The table above showed there were 13 training courses for medical and dental staff of which the trust only met the target for one module for equality, diversity and human rights. The trust did not meet the target for any other module.

Last year the medical and dental staff for medicine did not meet the training completion rate, reaching 82% for the financial year April 2016 to March 2017.

Staff we spoke with told us this was due to staffing shortages, which meant it was difficult for staff to be released for training.
There were 11 mandatory training courses applicable to registered nursing staff of which the trust met the target for three modules with the highest completion rate at 97% for equality, diversity and human rights training. From April 2016 to March 2017 nursing staff in the medical service at GDH met the 88% completion rate, and the service was close to this completion rate for the date period April 2017 to October 2017 (84%). Staff we spoke with told us the main reason the completion rates not being met was due to staffing levels. We saw this had been a long-standing problem and that it had been escalated to the nursing clinical cabinet. Managers showed us there was some improvement in attendance since October 2017 and they felt confident that targets would be met. All staff we spoke with had completed the required mandatory training.

Doctors we spoke with told us the majority of mandatory training was on line and time was allocated for completion. However, classroom based training; for example, basic life support (BLS) was often difficult to roster into a working day. Where possible training was included in departmental audit days. Mandatory training for medical staff was monitored through the appraisal system.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud Awareness</td>
<td>48</td>
<td>48</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>47</td>
<td>48</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>45</td>
<td>48</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>45</td>
<td>48</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>44</td>
<td>48</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>44</td>
<td>48</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>43</td>
<td>48</td>
<td>90%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>43</td>
<td>48</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>42</td>
<td>48</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>36</td>
<td>48</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>35</td>
<td>48</td>
<td>73%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>19</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>3</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training)
Safeguarding

There were processes in place setting out what the organisation and staff should do to keep people safe from abuse. The trust’s safeguarding policy could be found on the intranet, which was accessible to all staff. There was also a hard copy printed out and left in a resource folder on the wards. The policy for adult safeguarding was within the review date.

All the staff members we spoke with were able to identify abuse and describe the process in which they raised and reported safeguarding concerns. They gave examples of when this would be necessary.

There was a trust safeguarding team, and a safeguarding lead and ambassador within each ward or area. The process and key contacts for adult and children’s safeguarding was displayed in all patient areas we visited. All the staff we spoke with knew where and how to access this information if required.

In 2017 there was one safeguarding referral from ward 6 and one from ward 2.

Staff were aware of Female Genital Mutilation (FGM) and the process to follow should they have any concerns.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical/dental and for nursing staff in medicine at GDH is shown below:

Grantham - medical/dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>10</td>
<td>14</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>10</td>
<td>14</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>9</td>
<td>14</td>
<td>64%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>9</td>
<td>14</td>
<td>64%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Grantham – Qualified nurses

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>43</td>
<td>48</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>43</td>
<td>48</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>43</td>
<td>48</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>43</td>
<td>48</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Grantham and District Hospital met the 90% target for safeguarding training completion for nursing staff.

(Source: Routine Provider Information Request (RPIR) Training)
Cleanliness, infection control and hygiene

The medical areas inspected were visibly clean, tidy and free from clutter. We saw cleaning schedules completed in all areas we visited. Patients, relatives, and staff we spoke with consistently told us they were satisfied with the cleaning services in patient areas. Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning and decontaminating equipment, and for cleaning the environment. We observed nurses and housekeeping staff wiping down beds, chairs and equipment before and after use. Clean equipment was identified by ‘I am clean labels’ so that staff were clear when it was ready for use.

Cleaning equipment was available and colour coded in line with infection control guidance, to avoid cross contamination between clinical and non-clinical areas. A laminated poster provided information relating to the appropriate colour required.

Recording the number of infections on medical wards was limited to summaries of Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive Staphylococcus aureus and Clostridium difficile (C.Difficile) statistics. Based on the trust harm free care report, we saw there had been no cases of hospital acquired MRSA or MSSA from April 2016 to March 2017. There were four reported cases of C. Difficile in medical wards in the same period.

There was a nominated director of infection prevention and control (DIPC) with a dedicated specialist team whose role included the education of staff across the organisation on principles of IPC including hand hygiene.

The IPC team were supported by link staff in all ward areas, known as IPC ambassadors, who shared information and kept colleagues updated on IPC issues. We saw the ambassadors were from a range of different clinical disciplines, and were fundamental to successfully implementing and embedding ownership of IPC practice at ward or department level. The ambassadors undertook monthly audits of key aspects of IPC practice such as handwashing. The audits showed good hand hygiene standards were consistently observed in the medical division, with 100% compliance in all departments from January 2017 to February 2018.

During 2016-17 IPC study days were held on a quarterly basis for the ambassadors, rotating the venue between hospital sites. These provided a forum for exchanging ideas, and sharing best practice through focussed education, and networking with colleagues, and kept the ambassadors updated with relevant local and national IPC issues.

We observed all staff groups were bare below the elbow and actively washed and sanitised their hands before and after contact with patients in line with the National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3). Hand washing and sanitiser facilities and personal protective equipment (PPE) were readily available and clearly signposted in all departments we visited. We saw staff using PPE when appropriate.

We saw side rooms being used for isolation purposes where patients had a known or suspected infection, with doors shut and appropriate signage alerting staff and visitors of the infection prevention and control precautions to take. There was a clear isolation risk policy for them to follow. Each bed area had disposable curtains used for privacy and dignity. These curtains displayed dates of when they were last changed, all of which were in date. However, we noticed a non-disposable, non-wipe able privacy screen in the haematology / oncology unit. Staff we spoke with were unable to confirm how or when the screen was last cleaned or changed. We brought this to the attention of the nurse in charge, who told us corrective action would be taken.

Furniture was clean and in good condition, fully wipe-able and compliant with Health Building Note (HBN) 00-09: Infection Control in the Built Environment.
There were safe arrangements for the handling, storage and disposal of clinical waste, including sharps bins in accordance with HTM 07/01 The Safe Management of Healthcare Waste 2013. We saw sharps bins were securely kept and not full. We observed general and clinical waste bins in each bay and also in the corridors of the ward. These bins were not overfilled and were labelled clearly.

**Environment and equipment**

Systems were in place to ensure the patient environment was safe and secure with restricted access to clinical areas. Access was limited to specific staff using a digital keypad access system or intercom for visitors. Equipment was clearly labelled and stored in an organised fashion including in corridors.

Equipment was serviced by the trust or the manufacturer, with a record of equipment maintenance kept centrally. Monthly reports were produced of the equipment due for maintenance so that this could be scheduled within the timeframe and without interfering with clinical practice. Staff we spoke with told us they had no concerns about availability or suitability of equipment.

There was safe provision of emergency equipment with clearly signposted resuscitation trolleys and equipment used for the management of airways, sepsis, and hypoglycaemic (low blood sugar) emergencies. Staff informed us that the emergency equipment was always kept in the same place so that they knew where to locate it. There was piped oxygen and suction equipment in each bed space as well as call bells to be used in the event of an emergency.

Records we looked at showed emergency equipment was checked daily by staff that were competent to do so. Trolleys were locked with a breakable seal, which demonstrated equipment had not been opened, used or tampered with since it was last used.

All consumables we saw were appropriately stored and within their expiry date.

Products deemed as hazardous to health were in locked cupboards or clinical rooms or rooms that were only accessible to authorised staff.

Arrangements for the delivery and removal of waste and other equipment were clear. We observed waste being separated in to the correct waste disposal bags and saw that bins used for the disposal of sharp objects, for example, were filled to a safe level.

Wards and departments held regular morning team briefs known as ‘huddles’ where product and safety alerts were communicated. We saw information shared at ‘huddles’ was documented and displayed for staff not present. Information shared included equipment updates or when an item had been removed for repair.

GDH had elective admission exclusion criteria which excluded patients with a body mass index (BMI) of above 35. Therefore, there was limited equipment available specifically for the larger patient.

The medical service participated in the national patient-led assessment of the care environment (PLACE). PLACE enables assessors who have experience of the hospital environment to review areas used to care for patients against five areas: cleanliness; privacy; condition, appearance and maintenance; dementia and disability. In 2017 the medical service at Grantham scored between 55% for the environment for people with dementia, and 92% for cleanliness.
Assessing and responding to patient risk

The service had implemented the National Early Warning Score (NEWS) system developed by the Royal College of Physicians for the detection and response to clinical deterioration of adult patients on wards. In all of 45 patient records we looked at we saw the NEWS scores were completed electronically and acted upon. A mobile clinical system that monitored and analysed patients’ vital signs provided clinicians with real time information to provide risk scores and trigger the need for further intervention. We saw this happened throughout our visit and staff confirmed this was normal practice.

Staff we spoke with showed us that arrangements for managing deteriorating patients within the medical service were set out in standard operating procedures. From October 2016 there was no coronary care unit or intensive therapy unit at GDH. Staff were unclear about any plans to reopen either unit. Where patients on acute wards at GDH deteriorated they would be transferred to ACU (Acute Care Unit) at GDH which provided a higher level of care. The named consultant responsible for the patient would then have a discussion about the patient and agree a treatment plan with the Anaesthetic Team at Lincoln Hospital to help stabilise the patient and prepare the patient for transfer.

During our inspection we saw a patient on the Acute Care Unit who required more detailed observation than patients whose needs could be met on an acute medical ward. However; they were not transferred to the critical care unit at Lincoln in line with trust policy because there was no bed available. A critical care bed had been identified at a neighbouring trust as part of the critical care network; however, the patient deteriorated further and was not stable to transfer. The patient was subsequently cared for in ACU. We saw that one to one nursing was provided for this patient, and that their care needs were met.

We spoke with the head of nursing about the care of the patients on ACU. They reflected that the care needs of patients who presented to ACU were a risk, which had been highlighted and clear protocols were being created to minimise the risk. The risk was in the process of being added to the risk register. We spoke with a lead anaesthetist at the trust who assured us this was not a routine situation and the patient’s situation was complex. A review of the patient’s care had indicated their care and treatment was appropriate. The anaesthetist informed us that the standard operating procedures in place worked well and that there was a repatriation process to support the transfer of patients from ACU at GDH to the intensive therapy unit at Lincoln when required. We were given examples of when this happened.

There was a critical care outreach team, who supported staff with management of deteriorating patients on the wards. Staff told us that the critical care outreach team were easily accessed by ward staff to gain help for deteriorating patients, and we saw this demonstrated in patient records. Staff also told us that consultant advice or review was also available when needed. Out of hours the hospital at night team would also provide support and advice for the care of patients with complex needs.

There was a trust wide policy for sepsis management. Staff received training as part of the trust’s key learning programme, which included use of sepsis screening tools and application of the sepsis care bundle. A labelled Sepsis Six box containing the basic supplies required to commence treatment of a patient with suspected sepsis was stored with the emergency resuscitation equipment on each ward we visited. Sepsis Six is the name given to a bundle of medical therapies.
designed to reduce the mortality of patients with sepsis. A lead nurse for sepsis was based at Lincoln Hospital and was available for advice.

Sepsis is a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. We saw in three patients records we looked at that there was a sepsis screen performed on time in accordance with the local sepsis policy, and that there was appropriate escalation to doctors. We saw posters clearly displayed in patient areas as a reminder about the signs of sepsis. This was in line with NICE NG51 Sepsis: recognition, diagnosis and early management.

We reviewed 62 patient records in wards and units we visited across the medical service. We saw standard broad risk assessment tools completed on admission. These were followed by use of specific risk assessment for pressure ulcers, moving and handling, nutrition, falls, and dementia screening. All of the patient records we looked at also contained venous thromboembolism risk assessments (VTE) to determine the risk of a blood clot, which staff completed prior to treatment. The risk assessments informed staff if preventive treatments were required. We saw the VTE assessment had not been acted upon in one case; however, this was rectified during our inspection.

We saw daily safety huddles, ‘time to talk’ sessions and board rounds undertaken that highlighted patient risks.

Systems were in place for patients to follow after their discharge from the medical service. At discharge, patients were provided the ward or department telephone number or directed to the NHS 111 service, their GP, or the emergency department if they had concerns out of hours.

**Nurse staffing**

The service used a nationally recognised Safer Nursing Care Tool along with National Institute of Health and Care Excellence guidance to assess required nursing staffing levels. The acuity of patients was reviewed against the staffing numbers and skill mix with the medical service matron at least three times in each 24-hour period. Ward managers and a bed manager worked together to check staffing requirements and availability against gaps in the rota. However, staff we spoke with consistently told us that when the bed occupancy increased with escalation beds nursing staffing levels were not increased. During our inspection we saw this was the case on Ward 1, where there were two escalation beds occupied and Ward 6 where there were six escalation beds occupied during our inspection with no additional staff.

There were 122 less nursing staff than was planned by the trust to provide safe care. In October 2017 the trust required 53 whole time equivalent registered nurses in the medical service. However, there were 41 whole time equivalent nurses actually in post.

We saw concerns about staffing shortages recorded at the three most recently reported clinical cabinet meetings in November 2017, December 2017 and January 2018. For example, vacancies, sickness and maternity leave on Ward 1 accounted for a shortage of 10 registered nurses which equated to over 50% of the established staffing levels.

The risk of unsafe staffing levels had been recorded on the risk register from May 2016 and would be reviewed in May 2018. Staff and managers, we spoke with told us every attempt was made to cover gaps in staffing, either by permanent staff working overtime, using trust temporary staff known as bank staff, agency staff, or by ward co-ordinators (senior nurses) taking a case load and cancelling non-clinical shifts, or training. Staff from other wards and departments at GDH were moved on a regular basis in order to cover shifts. During our visit we saw all of these measures in place. However, the rotas did not always show whether additional staffing resources had attended. Staff and managers, we spoke with did not feel that the staffing levels were unsafe;
however, they told us that it was having an impact on completing appraisals, audits and training. We saw this confirmed in the minutes of the clinical cabinet meeting in January 2018.

From December 2016 to November 2017 the trust reported bank staff covered 958 shifts and agency staff were used to cover 701 shifts within the medical service and that, a total of 377 shifts were not covered.

We looked at staffing rotas and saw, for example, that for only nine out of 21 days in February 2018; actual staffing levels met the expected staffing levels on the EAU. Other shifts were short by at least one registered nurse or health care support worker.

During our visit the haematology and oncology day care service at Grantham was temporarily closed for three days due to a shortage of nursing staff. Nursing staffing levels in other areas were adequate, although there was some use of agency staff. We saw the trust had taken action to ensure that agency staff were provided with an induction and had access to the trust’s information systems.

**Vacancy rates**

From November 2016 to October 2017, the trust reported a vacancy rate of 18.7% in medicine; the target for the trust was 11.5% for registered nurses and midwives. At GDH the overall vacancy rate for registered nurses and midwives was 10.5% which was lower than the target. During our inspection managers told us the vacancy rate for nurses on ward 1 was 60% (7.56 whole time equivalent), and 26% for the Acute Care Unit (4 whole time equivalent) and on Ward 6.

(Source: Routine Provider Information Request (RPIR) Vacancy)

**Turnover rates**

From November 2016 to October 2017, the trust had a turnover rate of 8.3% in medicine; compared to the trust target of 7% and no staff group more than 20% above the target. The turnover rate at GDH was 6%, compared to 8 for the medical services at Lincoln County Hospital and 9% at Pilgrim Hospital, Boston.

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

**Sickness rates**

From October 2016 to September 2017, the trust reported a sickness rate of 5.3% in medicine; compared to the trust target of 4.5%. The sickness rate at Grantham Hospital was 8.4% which was higher than Lincoln County Hospital: 5.4% and Pilgrim Hospital, Boston 4.7%

**Bank and agency staff usage**

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 20.3% with a further 4.8% of shift remaining unfilled. A breakdown by staff type and location is shown below:

**Grantham Hospital**

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>728 (8.4%)</td>
<td>501 (5.8%)</td>
<td>129 (1.5%)</td>
<td>8,701</td>
</tr>
<tr>
<td>Unregistered</td>
<td>0</td>
<td>624 (10.0%)</td>
<td>255 (4.1%)</td>
<td>6,258</td>
</tr>
</tbody>
</table>

From December 2016 to November 2017 the trust reported bank staff covered 958 shifts and agency staff in the medical service at GDH were used to cover 701 shifts, a total of 377 shifts...
were not covered.

(Source: Routine Provider Information Request (RPIR) Nursing bank agency)

Medical staffing

The trust has reported staffing numbers for the period October 2017 for medicine. There were 43 less medical staff in place across the trust within the medicine core service than was planned to provide safe care. At GDH the planned medical staffing establishment was 38 whole time equivalents, however, the actual number of whole time equivalent medical staff in post was 28.

(Source: Routine Provider Information Request (RPIR) – Total staffing)

Vacancy rates

From November 2016 to October 2017, the trust reported an overall vacancy rate of 16.8% for medical staff in medicine; against a target of 12% for medical staff. At GDH the vacancy rate was 32.9%.

(Source: Routine Provider Information Request (RPIR) Vacancy)

Turnover rates

From November 2016 to October 2017, the trust reported a turnover rate of 8.3% in medicine; compared to the trust target of 7%, and no staff group more than 20% above the target. At GDH the turnover was 11.6%, compared to 7.2% at Lincoln County Hospital, and 21.5% at Pilgrim Hospital, Boston.

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

Sickness rates

From October 2016 to September 2017, the trust reported a sickness rate for medical staff of 2.59% in medicine; compared to a trust target of 4.5%. At GDH the sickness rate was 1.3%.

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

Bank and locum staff usage

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 20.3% with a further 4.8% of shift remaining unfilled. A breakdown by staff type and location is shown below:

County Hospital Louth

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>0</td>
<td>13 (1.3%)</td>
<td>1 (0.1%)</td>
<td>1,021</td>
</tr>
</tbody>
</table>

Grantham Hospital

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>728 (8.4%)</td>
<td>501 (5.8%)</td>
<td>129 (1.5%)</td>
<td>8,701</td>
</tr>
<tr>
<td>Unregistered</td>
<td>0</td>
<td>624 (10.0%)</td>
<td>255 (4.1%)</td>
<td>6,258</td>
</tr>
</tbody>
</table>
Information provided by the trust indicated there had been a steady increase in medical locum usage and expenditure for all grades of doctors, including consultants, from April 2016 to March 2017. Approximately 50% of the senior doctor cover (consultants) in the medical service was locum at the time of our inspection, which staff told us was due to ongoing difficulties recruiting to the posts. Junior doctors we spoke with felt well supported by the locum doctors, and the support from the outreach team.

(Source: Routine Provider Information Request (RPIR) Medical agency locum)

Grantham and District hospital had a designated medical (clinical) director who worked closely with consultants in substantive or locum positions at this location and who provided leadership, oversight and quality improvement in clinical medicine.

Consultant ward rounds were twice a day and staff told us access to medical support was good. **Staffing skill mix**

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

**Staffing skill mix for the 210 whole time equivalent staff working in medicine at United Lincolnshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>46%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>28%</td>
<td>23%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital - Workforce statistics (01/08/2017 - 31/08/2017)

**Records**

Patient records were accessible to staff caring for patients. A combination of paper and electronic patient records was in place. Arrangements for the management of patient records were set out in trust policies. Compliance with the policies should be audited on a monthly basis. We saw this happened as part of the ward accreditation processes. The safety and quality dashboard for Grantham and District Hospital, November 2017 indicated 100% compliance with required documentation for risk assessments including bed rail requirements, falls, pain management, pressure ulcers and malnutrition universal screening tool (MUST) assessments.

During our inspection we reviewed 62 sets of patient records, including nursing, therapy and medical notes, medicines administration records, and consent forms. All of the records we looked at were legible, dated and signed and maintained in accordance with national standards from the relevant professional regulators including the General Medical Council and Nursing and Midwifery Council.
Staff we spoke with told us it was easy to access diagnostic imaging and endoscopy results on the computer system and these were available shortly after the tests were undertaken. However, we were unable to assess this during our inspection as the endoscopy unit was temporarily shut.

**Medicines**

Medicines, including intravenous fluids and controlled drugs were generally stored, supplied and administered in accordance with the trust medicines management policy, medicines legislation, national standards, and against a written prescription by a doctor. The safety and quality dashboard GDH for November 2017 indicated 100% compliance with medicine storage safety.

Staff had access to the current British National Formulary both in hard copy and online. Staff on the wards described a good pharmacy service which included a daily visit from pharmacy staff, although this could vary when staffing levels were low. Staff reported no difficulties in accessing medicines out of hours as the site managers could access an emergency stock or contact the on-call pharmacist if needed.

Staff we spoke with told us stocks of medicines including controlled drugs (CDs) were checked daily by staff, and there were clear systems in place for reporting any stock discrepancies. Staff also told us they checked medicines stocks for expired medicines and rotated storage of medicines with a shorter date. However; we asked for evidence this was happening and were told there was no system in place for expiry date checking. On speaking to staff there was confusion regarding who was responsible for checking dates and this was not explicitly stated in the medicines management policy.  We looked at a random sample of medicines at all the locations we visited. Medicines with a limited shelf-life when opened were not always annotated with date of opening or date of expiry, therefore we could not be sure that medicines remained safe to use.

We found seven different medicines in the stock cupboard and fridge on two wards that had past the date when they should be used by. This included one item to be used in an emergency. The expiry dates ranged from November 2017 to February 2018. We brought this to the attention of staff and saw that the expired stock was removed.

There was evidence of daily stock checks of controlled drugs (CD), and CD audits. CDs were in good condition and their original packaging and we saw correctly completed entries in all of the CD registers we reviewed.

Temperature monitoring is a method of assuring that medicines have been stored in the correct condition, and is suitable for use. Medicines that required refrigeration were generally stored appropriately in locked fridges. The nurses undertook and recorded fridge temperature checks daily. Records we saw confirmed these were generally in the correct range. We saw one fridge in ACU which was recorded as greater than the required maximum range of eight degrees centigrade for six days in February 2018 and three days in March 2018. There was no evidence of actions taken in accordance with the trust policy although the facilities department had been notified.

We reviewed 22 medicines administration records and saw medicines reconciliation was completed and appropriately recorded by pharmacy staff. Medicines reconciliation is the process of creating the most accurate list possible of all medications a patient is taking, and comparing that list against the prescriber’s orders, with the goal of providing correct medication. Nursing and pharmacy staff assessed medicines that patients brought into hospital to ensure they remained safe to use. We saw that eight medicines prescribed across the 22 records we looked at appeared to have been omitted on one or more occasions, for example there was no signature present to indicate administration. None of the omitted medicines would be considered critical medicine.
Staff could only access clinical rooms that held medicines through a secure digital key pad access. Tamper evident seals were in use for emergency medicines to ensure that they were readily available when needed and for use. We saw that regular checks of emergency medicines and equipment were carried out by staff.

The trust electronic reporting system report from November 2017 had identified omitted medicines to be the most common type of medicines error. Staff we spoke with were aware of this and identified that monitoring and learning from incidents were part of the ward accreditation and assurance process.

We saw that nurses completed training before administering medicines and repeated this every three years, or with individual staff in response to errors or incidents as part of ongoing professional development. This was through completing an eLearning package supported by observation and questioning and a competency framework from the point of induction training.

NICE Quality Standard 61 recommends that people are prescribed antibiotics in accordance with local antibiotic formularies. Records we looked at confirmed that there were local protocols and formularies in place, and that these were followed correctly by prescribing doctors. We also saw that prescribed stop dates were recorded in line with good antimicrobial stewardship.

In all patient records we reviewed staff had recorded allergies clearly and taken relevant action to ensure known allergies were acted upon, and we saw that red wrist bands were worn to identify patients with allergies.

Although there was a policy for the self-administration of medicines, staff told us that this was rarely used on the wards, and we saw no evidence of it being used during our inspection. Staff told us that patients would administer their own inhalers under supervision from nurses. In these situations, a full self-administration risk assessment was not deemed necessary.

Medicines to take out after leaving hospital (TTOs) were contributory to patients waiting to go home. We spoke to a pharmacist who explained there was a shortage of pharmacists to meet demand. Wards were required to request TTO’s in advance of discharge, preferably the day before or in the morning. However, this was not always achieved.

**Incidents**

Staff understood their responsibility to report concerns and record safety incidents. At our previous inspection staff told us they did not always receive feedback from the incidents they reported, so lessons were not being learnt. During our inspection, one manager told us they felt concerned incidents were sometimes investigated by staff in the area in which the incident had been raised, and that they did not always receive feedback. However, staff were generally able to provide examples of learning from incidents, which had been disseminated across all sites within the trust.

A safety incident occurred during our inspection where an agency nurse had mistakenly taken the medicines keys home. We saw that the incident was reported on the patient safety electronic reporting system and appropriate corrective action taken and that staff had been reminded of their responsibilities in the security and return of keys at the end of their shift. Staff told us there was no procedure to record keys being issued or returned.

At the time of our visit there were 12 open incidents in the medical service at GDH, all of which were graded as low harm.
Staff we spoke with reported good awareness of incidents occurring in their areas as well as across the trust, with a cascade process ensuring information was disseminated from head of nursing to matrons to ward sisters and then to staff through ward meetings, daily safety huddles, email and communication books. Whilst all staff knew how to report medicines incidents or errors, managers we spoke with did not think that all staff would report all instances where medicines had been missed. They told us that patient harm incidents were reported.

**Duty of Candour**

Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. The service had a system in place to ensure that patients were informed when something went wrong, given an apology and informed of any actions taken as a result. Staff we spoke with from all levels of the organisation showed an understanding of duty of candour, when they would use it, and the actions they would take. Staff were introduced to this during their induction programme as part of their corporate essential learning.

**Never Events**

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

There had been no reported never events at Grantham and District hospital in the twelve months January 2017 to December 2017. However, we saw that there had been shared learning from never events that had occurred at other ULHT hospital sites; two in the surgical division at Lincoln Hospital in December 2017 and January 2018, and one in the medical division at Pilgrim Hospital, Boston in December 2017. Reviews of the events were undertaken and staff we spoke with were able to describe shared learning across the organisation. As a result of the December 2017 never event, the trust was in the process of undertaking a rapid review of all relevant policies, procedures and competencies aligned against the National Patient Safety Agency, NICE guidance and NHSI improvement notice issued to ULHT through the Trent critical care network in 2017. The trust had a draft revised policy which stated that only staff who have competency for insertion and care of naso-gastric tubes were allowed to undertake the procedure. We saw some nurses on the medical and surgical wards we visited had been assessed as competent in February and March 2018. The quality matrons were continuing to work with all nursing staff to assess their competencies. They demonstrated this was a high priority in their work and we saw that they were carrying out the competency assessments at least once a week.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 137 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from December 2016 to November 2017. Of these, eight were reported at GDH, 52 at Lincoln County Hospital, and 77 at Pilgrim Hospital, Boston. The most common types of serious incident reported across the trust were:

- Pressure ulcer meeting SI criteria with 50 (37% of total incidents).
- Slips/trips/falls meeting SI criteria with 30 (21% of total incidents).
- Treatment delay meeting SI criteria with 19 (13% of total incidents).
- All other categories with 15 (12% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 12 (9% of total incidents).
- HCAI/Infection control incident meeting SI criteria with 11 (9% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

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

The results of the safety thermometer were displayed in all wards we visited. We saw that wards and departments were consistently scoring highly in the majority of metrics measured.

Data collection takes place one day each month – a suggested date for data collection was given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Data was then recorded on a safety quality dashboard as part of the ward assurance framework and reported to the clinical cabinet forum for each directorate.

Data from the Patient Safety Thermometer showed that the trust reported 61 new pressure ulcers, 71 falls with harm and 11 new urinary tract infections in patients with a catheter from December 2016 to December 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at United Lincolnshire Hospitals NHS Trust

(Source: Safety thermometer - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

We reviewed 62 patient records during our visit and saw patients’ care was planned and delivered in line with evidence-based guidance such as those published by National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies, and was supported by local guidelines and standard operating procedures.

We saw that staff including temporary staff, were equipped with the necessary guidelines and standard operating procedures to carry out their work effectively. Policies, protocols and standard operating procedures were available on the hospital’s intranet. We saw staff used the intranet to access the relevant documents. Wards and departments also kept hard copies of the guiding documents so that staff could access these in the event of IT downtime. The majority of policies we reviewed had a document owner, a date of approval and a date for review to ensure the most up to date version was referred to. However, we saw a recently issued policy for naso-gastric tube insertion and care that did not have a publication or review date. We brought this to the attention of the nurse in charge, who confirmed this was a draft policy and that it was the current version.

The Trust induction programme provided an orientation to the aims and values of the Trust as an organisation, together with information about the key policies and procedures relating to the organisation’s safety, training and information requirements.

At the time of our inspection staff told us that no patients were detained under the Mental Health Act 1983. However, staff could tell us about when people had been detained previously and how they were treated.

There was a comprehensive audit schedule in place and staff were aware of this.

Nutrition and hydration

Staff used national guidance tools to assess patients’ hydration and nutrition needs that were set out in an up to date nutrition and hydration policy. The trust collected data to inform compliance with food standards. These standards included screening of patients at risk of malnutrition using a national malnutrition universal screening tool (MUST). The MUST score was completed within 24 hours of admission, and then weekly or more frequently if necessary. In all of the patient records we looked at we found these were fully completed by staff.

One patient told us: “The catering staff are always very helpful. The food is good”. We saw that protected mealtimes allowed patients to eat their meals without unnecessary interruption. Staff assisted patients with eating and drinking or enabled their relatives to do so where appropriate.

Staff were able to access meals and refreshments for patients’ different dietary requirements based on personal preference, cultural needs and specialist diets.

Patients were referred to dieticians and speech and language therapists based at GDH if required. Wards had (nurse) ambassadors for nutrition who shared information, and were able to offer advice to colleagues.

We saw patients in all patient areas we visited were offered refreshments at regular intervals.
**Pain relief**

Staff documented patients’ pain scores electronically. Patient on the wards told us staff managed their pain well by offering regular pain relieving medicines. We reviewed medicine administration records and found that medicines had been given as prescribed. We did not see any omission of pain relieving medicines without a valid reason.

The trust specialist pain service were part of the outreach team. All registered nurses could refer patients to the pain team or anaesthetist if they were concerned that patients were in pain. Allied healthcare professionals and healthcare assistants reported to the registered nurses if patients complained of pain to ensure it was acted on.

**Patient outcomes**

The medical wards took part in a number of local and national clinical audits, detailed below. Mortality and morbidity reviews were undertaken and discussed at clinical governance meetings.

**Relative risk of readmission**

**Trust level**

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

**Elective Admissions – Trust Level**

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

**Non-Elective Admissions – Trust Level**

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

**Grantham and District Hospital**

From September 2016 to August 2017, patients at Grantham & District Hospital had a lower than
expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average. However, for non-elective admissions:

- Patients in Cardiology had a higher than expected risk of readmission
- Patients in Clinical Oncology (Previously Radiotherapy) had a higher than expected risk of readmission

**Elective Admissions - Grantham & District Hospital**

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

**Non-Elective Admissions - Grantham & District Hospital**

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

**Sentinel Stroke National Audit Programme (SSNAP)**

The trust participated in the quarterly Sentinel Stroke National Audit programme. This was not completed at GDH as the trust managed acute stroke services at Lincoln County Hospital, and Pilgrim Hospital, Boston.

**Myocardial Ischaemia National Audit Project (MINAP)**

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

From April 2015 to March 2016, 33.3% of nSTEMI patients were admitted to a cardiac unit or ward at Grantham and District Hospital and 95.5% were seen by a cardiologist or member of the team compared to an England average of 55.8% and 96.2%. The proportion of nSTEMI patients who were referred for or had angiography was 44.4% compared to an England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))
Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 1.0%, which does not meet the audit minimum standard of 90%. The 2015 figure was not available.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 16.4%, this was significantly worse than the national level. The 2015 figure was not available.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 58.3%; this is not significantly different from the national level. The 2015 figure was not available.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 48.6%. This is not significantly different from the national level. The 2015 figure was not available. The one-year relative survival rate for the trust in 2016 is 31.4%.

(Source: National Lung Cancer Audit)

We saw trust wide and local action plans in place to attain improvement in areas of poor scores. These were regularly reviewed. We saw in some action plans that actions had been completed. Staff were aware of these action plans.

Competent staff

All staff we spoke with told us they felt supported to participate in learning and were able to provide evidence of ongoing professional development. Nurses we spoke with had completed their NMC revalidation and felt they had been fully supported throughout the process. We saw a detailed induction programme for permanent and temporary staff.

There was an Induction and Core learning Training Policy, dated January 2015. The document included core learning needs analysis, which outlined staff groups, initial training, refresher training, duration and methodology (classroom and e-learning), required update period, additional requirements and accreditation status. Additionally, the policy included a standard operational policy for agency nurse Induction and checklist. We saw the checklist being used with an agency nurse during our inspection.

Volunteer staff employed at the trust underwent a recruitment process, which mirrored the requirements for all other hospital staff (application form, disclosure and baring system checks and two references). There was an induction checklist specifically for volunteers.

Medical staff had an annual budget for training and conference attendance to support their professional development. Nursing staff were required to apply to the trust for access to training or conference attendance. However, nurses told us there were limited resources to support their application. The head of nursing told us funding was available and requests were reviewed based on relevance and equality of access for all nursing staff.

Audit days were compulsory and attended by medical and nursing staff. They were organised at departmental level to address mandatory and specialist training needs.

Appraisal rates

From April 2017 to October 2017, 66.2% of staff within medicine at the trust had received an appraisal compared to a trust target of 85%.
A split by staff group can be seen in the graph below:

![Graph showing appraisal completion rates](image)

Grantham Hospital had a 61.0% appraisal completion rate with 61 from 100 having received an appraisal.  
(Source: Routine Provider Information Request (RPIR) Appraisals)

**Multidisciplinary working**

Multidisciplinary working was evident in the areas we visited. Staff generally described good collaborative working practices with multi professional teams. Examples included working with medical staff, therapists, clinical nurse specialists, the mental health liaison team, palliative care service, tissue viability service for patients with pressure ulcers or complex wounds, and the critical care outreach team for patients at risk of deterioration or sepsis, and patients who needed pain management.

During our inspection we saw regular consultant-led multidisciplinary meetings or rounds with therapists in clinical areas. We saw the treatment planned documented in-patient records we reviewed. For example, occupational therapists, physiotherapists, dietitians and speech and language therapists documented patient progress within the patient care record. This enabled a joined-up approach to assessment of patients’ needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

Information regarding a patients’ stay in hospital including the treatment and care undertaken and prescribed medicines was sent electronically to their GP on discharge. Patients were also given a paper copy to take home.

Nursing and medical staff told us they had a positive relationship with the pharmacy team, who they described as approachable, accessible, and knowledgeable.

**Seven-day services**

Medical consultants provided a seven-day service across the directorate. This meant that medical patients were reviewed at least daily, and patient admission reviews and discharges could be facilitated through weekends.
There was physiotherapy cover in the medical wards at weekends; however, occupational therapy, dietetic, and speech and language therapy services were provided from Monday to Friday only, with no service at weekends. This meant that rehabilitation of patients was not maximised.

Clinical pharmacy services include pharmacists, technicians, and assistants and covered designated wards five days per week. There was no routine clinical pharmacy service available at weekends, however, medicines supply and advice was available 24 hours a day, seven days a week.

Staff we spoke with told us that diagnostic imaging and haematology services were also available 24 hours a day, seven days a week, if required.

**Health promotion**

Staff supported patients, and their relatives where appropriate, to manage their own health and wellbeing, and to maximise their independence. Staff told us this was aligned with the NHS initiative Making Every Contact Count: using every opportunity to achieve health and well-being, which aims to support people to make and maintain positive lifestyle changes to improve health and wellbeing.

Patients with a high body mass index were referred to Lincoln County Hospital for dietetic advice where relevant.

Patient records we looked at showed that staff discussed eating well, exercise, smoking cessation, and alcohol consumption. People who were smokers were referred to the smoking cessation services.

We saw information about signs of sepsis, and smoking cessation clearly displayed on notice boards in public areas throughout the hospital, including waiting areas.

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

The trust target for completion of Mental Capacity Act and Deprivation of Liberty Safeguard training was 90%. The trust reported from April 2017 to October 2017 Mental Capacity Act (MCA) training had been completed by 85% of staff within medicine. The completion rate for was 87% for nurses, and 82% for medical and dental staff.

The trust has confirmed that the deprivation of liberty safeguard training is in included in the mental capacity act training module provided by the trust.

(Source: Routine Provider Information Request (RPIR) Training)

Staff we spoke with gave examples of where mental capacity assessments had taken place for: administration of medicines, consent to treatment and investigations, physiotherapy and occupational therapy interventions and personal care. We saw these were fully documented in patients’ records.

We saw information displayed in patient areas, which included reference to MCA and access to support for people with mental health needs. Patient records we looked at showed that staff completed MCA assessments for all patients admitted.
Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005, and aim to make sure that people in hospital are looked after in a way that does not restrict their freedom. We saw arrangements in place to ensure the CQC is informed about any Deprivation of Liberty Safeguard (DoLS) applications in line with Regulation 18 of the Health and Social Care Act 2008 (Registrations) Regulations 2014. Managers we spoke with told us processes were in place for assuring all patients requiring DoLS were completed. The trust safeguarding lead received a list from wards and also a list from county council, and audit DoLs notes quarterly particularly focusing on at risk wards.

An urgent authorisation is put in place for up to 7 days for patients identified as potentially deprived of their liberty, (extended to 14 days only in “exceptional circumstances”). However, we saw one DOLs in place at the time of our visit did not have each stage of the process documented and there was no record of the DoLS authorisation being reviewed on the due date of 25 February. We brought this to the attention of the Head of Nursing who confirmed the initial authorisation was requested by the ward to Lincolnshire County Council and a decision was still awaited. The authorisation had therefore lapsed. However, the trust safeguarding lead discussed the use of a safeguarding care plan that would document each stage and identify when each stage of the process was due.

There was a do not attempt cardiopulmonary resuscitation (DNACPR) policy which included instructions for staff. DNACPR is a legal document that patients or their loved one’s sign in the presence of witnesses. We saw three DNACPR orders which were all completed in accordance with the policy.

Staff were aware of different types of consent. We observed staff gaining consent prior to undertaking nursing care.

Is the service caring?

Compassionate care

In all patient areas we visited we observed positive interactions between patients and staff. All staff actively supported patients and relatives upon admission, during their stay, and when they were ready for discharge. We saw staff maintained patients’ dignity, privacy and respect. The staff concerned included clinical and ancillary staff. Doors to patients’ rooms were closed and privacy curtains were drawn when personal care or clinical examinations were carried out.

Patients and relatives, we spoke with consistently told us about the kindness of the staff across the medical division, and spoke positively about their patient experience. One patient said: “The staff are very good and helpful: I feel safe here. If I press my buzzer someone will come and help me”. Another patient said “I have been here nearly four weeks and I could not have been any better looked after. I have had first class service”.

Emotional support

Staff we spoke with understood the impact that a patient’s condition, treatment or care could have on their wellbeing. Staff and patients, we spoke with also told us emotional support was available from a multi-faith chaplaincy service. We spoke with a chaplain who told us that they visited the medical service on a regular basis and when they were asked. We saw they visited ward areas
during our inspection. We also saw the hospital chapel provided a multi-faith service for patients and their families and staff.

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

Patients we spoke with told us that details of their care and treatment were explained to them without them having to ask. They said they felt involved in the decision-making process of their care and felt fully informed of their treatment plan.

Families and carers were supported in flexible visiting where appropriate, and were encouraged to assist with meal times for patients who would benefit. We saw discussion with family members or carers recorded in patient records.

**Friends and Family test performance**

From December 2016 to November 2017 the Friends and Family Test response rate for medicine at the trust was 28% which was better than the England average of 25%. At Grantham and District Hospital there was a 34% response rate (total of 524 responses)

The friends and family test percentage recommended by ward for medicine at the trust is shown in the table below:

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Ann. Perf.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day cases</td>
<td>2,081</td>
<td>28%</td>
<td>97%</td>
<td>95%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>98%</td>
<td>96%</td>
<td>96%</td>
<td>93%</td>
<td>96%</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward 1</td>
<td>175</td>
<td>40%</td>
<td>94%</td>
<td>100%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 6</td>
<td>252</td>
<td>83%</td>
<td>%</td>
<td>%</td>
<td>95%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>96%</td>
<td>96%</td>
<td>89%</td>
<td>96%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Average length of stay**

From October 2016 to September 2017 the average length of stay for medical elective patients at the trust was 3.2 days, which is lower than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 6.4 days, which is lower than the England average of 6.6 days. The average length of stay for elective patients in clinical oncology (previously radiotherapy) is lower than the England average. It was also lower for cardiology and clinical haematology. Average length of stay for non-elective patients in cardiology and for geriatric medicine was both higher than the England average. The average length of stay for non-elective patients in cardiology and for geriatric medicine was both higher than the England average.
From October 2016 to September 2017 the average length of stay for medical elective patients at Grantham and District Hospital was 3.8 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 6.1 days, which is lower than England average of 6.6 days.
Meeting people’s individual needs

At the time of our visit the endoscopy unit at GDH was closed for refurbishment, from 25 February 2018. Managers told us it was due to reopen on 15 March 2018. The haematology and oncology day care unit was also temporarily closed from 28 February 2018, due to nursing staff shortages. Staff we spoke with told us and we saw that all patient appointments had been rescheduled at other hospital sites within the trust in order for patient’s needs to be met.

During our visit, we saw six patients who required medical specialities care being cared for on a surgical ward at GDH due to no available medical beds. Staff told us that the demand for medical beds was a longstanding issue within the trust and was not featured on the trust risk register. Actions were in place to ensure patients were reviewed by medical staff on at least a daily basis, and when there was a change in their clinical condition. Patients and staff, we spoke with told us they felt confident in the skills and knowledge of staff caring for those patients. Staff had completed relevant training and were able to access specialist advice from members of the multidisciplinary team and clinical nurse specialists when needed.

Staff within the medical service spoke positively about the services provided for people with mental health needs, under a service level agreement by another NHS trust for patients. The service was located at the Grantham and District Hospital from Monday to Sunday 9am to 5pm, with a crisis team available outside of those hours. There was support in place for vulnerable people such as people living with dementia or mental health needs. There were similar arrangements for access to the services for people with a learning disability. Flexible visiting hours were in place for carers.

A dementia care bundle had been developed in partnership with the Alzheimer's Society, Carers First and commissioners. The trust had identified five aims based on best evidence and practice and designed actions for staff to consider and to follow that were set out in a dementia care strategy. Staff we spoke with knew how to access the relevant information. We saw dementia ambassadors had been appointed to provide a link between the clinical areas and the dementia service.

Every patient aged 75 years or over was required to have a dementia screening assessment. The dementia care bundle acknowledged that some patients may have early onset dementia however it was anticipated that in these circumstances existing assessments and investigations would determine this.

Staff we spoke with also spoke positively about the service provided for people with a learning disability. The trust had two learning disability (LD) specialist nurses who could be contacted for advice.

We saw a wide range of information available to patients and visitors. Including carers’ noticeboards.

Face to face and telephone translation services were available at the trust for people whose first language was not English. Staff spoke positively about the service, although they had not had to use it on a regular basis.
Access and flow

The service had a live electronic reporting system which showed when a patient was fit for discharge or had past their expected discharge time. The bed manager visited all patient areas at least daily and reviewed the capacity of each area. A hospital wide bed meeting was held at least daily and attended by a nominated individual from each area. We attended one bed meeting and observed discussion around bed capacity, and noted 17 extra medical beds above the commissioned bed allocation were referred to during the meeting. Managers confirmed this was to help improve access and flow. This was happening on a regular basis at times of (winter) pressure.

Staff told us discharge into community care establishments was sometimes a problem due to little availability locally.

Managers told us the service was using the ‘Red2Green’ approach, which is a visual management system that is designed to assist in the identification of wasted time in the patient’s journey. Red2Green helps to reduce overall bed occupancy and improve patient flow. A red day is when a patient waits for more than 14 hours for an intervention, such as a diagnostic test, therapy or senior clinical review- when, for whatever reason, nothing happens to progress a patient’s discharge from hospital. If these delays are avoided, it is a green day.

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

Trust’s referral to treatment time (RTT) for admitted pathways for medicine has been similar to the England average for the whole-time period between November 2016 and October 2017.

In October 2017 (and November 2017) the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.

From November 2016 to September 2017 the trust showed an average of 75% versus the England average of 90%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

Four specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>71.7%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>63.2%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>88.9%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>74.7%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Senior managers told us they were taking steps to improve RTT. This included a review of all activity, additional outpatient sessions and ad-hoc clinics. The effectiveness of these actions were monitored through a daily report on all 12 week waits, full consultant led harm reviews weekly and designated weekly cancer RTT and risk meeting. To facilitate the time commitment required these actions had been recognised and included within consultant job plans.

Where there was an increased demand for bed capacity, there was a medical outlier’s policy used by clinicians in collaboration with managers and a bed manager to ensure the safe placement of patients outside the speciality bed area. During our visit we saw this policy was followed and that six medical patients were placed on a surgical ward. Staff we spoke with on the surgical ward were able to demonstrate they had the necessary skills and experience to care for the patients, and managers and staff told us that patients would be transferred to a medical speciality ward at the earliest opportunity. In addition, extra beds known as escalation beds were allocated on a temporary basis, at an extra cost to the trust. There were standard operating procedures in place to ensure that decisions to use escalation beds followed a risk based approach, and were authorised by the executive management team.

Patient moves per admission

The trust reported that there were 300 occasions at GDH when a patient had a ward move between 22:00 and 08:00am from November 2016 to October 2017. This was an average of 25 a month.

(Source: Routine Provider Information Request (RPIR))

Learning from complaints and concerns

Patients, families and carers knew how to make complaints and raise concerns. We saw posters and leaflets informing patients and visitors on the process and how to contact the Patient Advice and Liaison Service (PALS) which was located in a quiet office near to the medical wards.

At our last inspection in 2015 there had been a significant backlog of complaints. From October 2016 to September 2017 there were 188 complaints about medical care across the trust from a total of 750 complaints. The trust took an average of 75 days to investigate and close complaints; this is not in line with their complaints policy, which states complaints should be completed within 35 days (80% of them) and complex complaints should be responded to within 50 days. The top three categories reported for medicine were communication with patient (21) followed by communication with relative/carer (18) and 15 associated to delay or failure to diagnose (including for example, a missed fracture).

(Source: Routine Provider Information Request (RPIR) Complaints)
Staff gave examples of when learning from complaints was shared at staff meetings and in training sessions.

There were 13 complaints at GDH; the top two categories reported against were communication with relatives/carers (four) as well as delay or failure to diagnose. All complaints were being appropriately managed.

### Is the service well-led?

#### Leadership

Each ward or department had a nurse manager or charge nurse leading each shift, however we saw that they were usually taking a case load of patients as there were insufficient numbers of staff to allow non-clinical time. There was a matron for the medical service, and a head of operations and nursing. There was a medical director who provided leadership, oversight and quality improvement in clinical medicine, a head of each therapy department, and a chief pharmacist.

From 2017 the trust measured the quality of care delivered to patients in the ward environment through the process of ward accreditation. A team of five quality matrons had been recruited to lead on ward accreditation Leadership of the matrons was provided by the deputy director of nursing. The quality matrons undertook assessments and supported staff in quality improvement at ward level and through trust wide initiatives such as safety huddles. At the time of our inspection all medical wards had begun the ward accreditation assessment process.

Staff described the local leadership team as visible and approachable including the CEO, Chief Nurse, Medical Director and Matrons. Following our inspection, we received information from a number medical staff who described the clinical director as not approachable and did not act their concerns. We raised this with the senior management in the trust.

Managers we spoke with were positive about the impact of the quarterly multi professional senior leadership forum meetings introduced in 2017. The forum was chaired by the chief executive officer and staff felt it had improved networking across the trust and increased understanding of the trust’s vision and strategy.

#### Vision and strategy

The trust had a long term strategy called ‘Our Ambitions 2021’. Staff told us this had recently been displayed around the trust. Although staff were generally unaware of trust or local strategies, all were very aware of maintaining patient flow and the focus on quality improvement and ward accreditation.

There was a ULHT clinical services strategy 2017-2022 dated February 2018. This set out the trusts vision for clinical services for the next five years. The strategy had been developed with external partners and the process of commencing more in-depth discussions with the trusts commissioning groups were due to begin. Staff we spoke with had not been part of developing their strategy. We did however see evidence staff had been involved in this process.

Senior staff told us there were discussions around the review of clinical services across the trust. Whilst there was no agreement as to which direction the trust was going to take, staff felt unsettled about closing/moving services.

The trust vision and values were clearly displayed in patient areas. The vision was to provide ‘excellence in rural health’, and was supported by five values and a staff charter. The five values

Evidence appendix United Lincolnshire Hospitals NHS Trust
were stated as: ‘the delivery and development of our services will be patient centred, we put patient safety and well-being above everything, we measure and continuously improve our standards, striving for excellence at all times, we offer our patients the compassion which we would want for a loved one, and we show respect for you and for each other’. Staff we spoke with knew where to locate the vision and values. We saw staff delivered care in line with the trust values.

**Culture**

Most staff we spoke with told us they felt positive about the direction of the trust and liked working in a smaller hospital as it meant that communication generally worked well. Nursing staff told us they were confident in raising concerns with their managers, however following our inspection a number of medical staff told us they would not feel confident to raise concerns with their manager. We raised this with the senior leaders in the trust who assured us they would take action to improve this.

The trust had completed the NHS workforce race equality standard (WRES) indicators report in August 2017, which is a requirement for NHS commissioners and NHS healthcare providers. The report indicated there had been a considerable amount of work to promote racial equality across the organisation. This included the launch of a British black, Asian, and minority ethnic (BAME) network in July 2017, sponsored at board level, a smart phone application and focus groups. The report showed the trust’s employees represented the overall diversity of the local population. However, it identified areas of inequality for which action was required. For example, the report stated, ‘We must do more to ensure that both females and black and ethnic minority (BME) candidates have equal opportunity to progress to senior positions in this organisation’. Staff spoken with during our inspection told us they had equal opportunities for development within the trust.

There was a lesbian, gay, bisexual and transgender (LGBT) network which considered employment or patient related issues from an LGBT perspective. Additionally, we saw a poster advertising a meeting entitled ‘Let’s talk disability’.

Staff worked well as a ward team and as a hospital with other departments. They were all committed to delivering good patient care. There was a culture of putting patients first. Morale across the wards was mixed; staff described staffing shortages as the biggest concern to morale.

**Governance**

There were a number of initiatives in the medical service designed to monitor clinical practice and identify and assess risks to patients. These included ward rounds, board rounds, the golden hour, a clinical cabinet and safety quality matrixes.

The golden hour was protected time where the matron carried out an improvement walk and included on the spot audits of the environment, patient’s records, staffing levels, bed capacity, clinical observations and medicines administrations. Immediate feedback and follow up action was discussed with staff so learning could be implemented effectively and immediately.

The clinical cabinet was made up of senior nursing staff with a purpose of providing clinical direction and ownership of the strategic vision for the service.

Staff also participated in a morning huddle and handover where patient’s needs were discussed and high-risk patients were identified. Staff would be told if there were any patients with specific needs overnight so they could review them as soon as the huddle had been completed.
From 2017 the trust measured the quality of care delivered to patients in the ward environment through the process of ward accreditation. Staff we spoke with explained that this was work in progress and that the link between ward accreditation and the governance structure was enabled by the recent appointment of a named quality matron for each standard. These roles provided a link between the programme and the quality committee in topics such as infection prevention and control (IPC) falls, and medicines optimisation, for example. Bi-monthly reports were submitted to the Patient Safety Committee and quarterly to the Quality Governance committee. Managers told us further work was required to embed ward accreditation to speciality and business unit governance meetings.

The trust Infection Prevention and Control Committee (IPCC) had corporate responsibility for all infection prevention issues and monitoring the progress of the annual infection prevention programme. The IPCC met monthly and had the following sub-committees, which provided regular reports to the committee meetings: Trust Decontamination Committee, Trust Water Safety Group, Antimicrobial Stewardship Strategy Group, Individual Site Infection Prevention meetings, and the IPC Operational meeting.

The IPCC received surveillance reports on HCAI’s, HCAI associated deaths, relevant RCA and PIR investigations, antimicrobial pharmacist reports, results of the antibiotics audits, and reports from the site IP meeting chairs. The trust also had two full time sepsis practitioners with the overall role of providing clinical leadership, raising awareness, ensuring early recognition and intervention and promoting the use of sepsis screening and management tools. Mortality and morbidity discussions took place twice weekly and any learning from these meetings would be shared with the medical division.

In order to ensure the Trust responsibilities for safeguarding were met, a safeguarding committee reported to the Trust Board through the Quality Governance Committee. Over the past year, an external review of the safeguarding team was undertaken, with recommendations made to improve the Trust’s compliance with Regulation 13 and other statutory obligations, and to review the current capacity within the team.

The Chairman of the Medicines Optimisation and Safety Committee attended the Patient Safety and Clinical Effectiveness Committee and the Quality Governance Committee to report on Medicines Optimisation and Safety issues when relevant.

**Management of risk, issues and performance**

There was an electronic risk register in place for identifying, recording and managing risks. We reviewed the risk register during our visit and saw 15 risks recorded for the medical service. The register contained a description of each risk, dates of when the risk was raised and to be reviewed, controls in place, gaps in controls, named people responsible for the risk item, and assurances. The risks were updated to change their risk rating. Current issues on the risk register reflected those raised by managers and staff we spoke with. They included: inadequate recruitment of consultants into substantive roles, difficulties finding cover for staff vacancies, sick leave and annual leave along with environmental risks.

A safety quality score card was completed each month covering a range of metrics, these were displayed in ward areas we visited.

**Information management**

Service performance measures were reported and monitored. The ward managers and matrons had access to a quality and safety dashboard at all times, that displayed performance measures. This information was also displayed on ward noticeboards for patients and visitors to see how well the wards were performing.
Trust policies stated that all records which included patient-identifiable information must be stored securely and kept strictly confidential within the establishment. We saw this to be the case throughout our visit.

**Engagement**

Medical wards held regular team meetings, which were documented. These provided relevant updates about the department, the division and the wider trust. A staff huddle took place at the beginning of each day for sharing and learning purposes. Staff told us this was a good opportunity to find out what was going on and discuss important issues. Nursing staff spoke positively of being involved in decisions and new ways of working, we saw evidence from staff meetings where local and trust developments had been discussed.

The trust staff survey 2017 results showed a score of 3.6 with one indicating staff had little engagement and five indicating highly levels of staff engagement. This was slightly down on the 2016 result of 3.75.

The chief executive sent a weekly email to all staff. This included what was happening in the trust, information about national visits, awards given and health information such as the availability of the flu vaccine. Uptake by staff of the flu vaccine was reported to be 72% in October 2017.

The trust had a ‘staff engagement on 2021’ strategy. The document outlined how staff were being engaged in discussions about the future of United Lincoln Hospitals NHS Trust (ULHT). A survey of staff had established common themes for the trust to consider when developing the 2021, five-year strategy. A key theme was to make better use of workforce, improving recruitment and retention of staff. Additionally, the survey gave an opportunity for staff to put forward ideas which could save money or increase revenue. For example, investment in renewable energy, improve clinical coding (this ensures a trust receives payment for work completed) and reduce waste. The survey indicated 64% of staff who took part knew ‘a little bit’ about the trust five-year plan. However, only 18% were confident the strategy would transform ULHT.

The trust had an annual awards programme to recognise individuals or teams for hard work and contributions to good patient care. Any member of staff could nominate a colleague or team for an award.

The trust had a ‘Public engagement on 2021’ strategy to consult with the public and service users about the future of United Lincoln Hospitals NHS Trust (ULHT). The trust had contacted over 110 groups and attended 57 public meetings. The key conclusion was people would prefer services closer to home wherever possible, although people accepted specialist services where the expertise was available. The public understood the current NHS issues. Including recruitment, finance and safety.

Grantham & District hospital friends and family Grantham & District hospital friends and family survey results showed 87% of patients, out of 2127 who completed the survey, would recommend the hospital to family and friends.

From December 2016 to November 2017 the Friends and Family Test response rate for medicine at the trust was 28% which was better than the England average of 25%. At Grantham and District Hospital there was a 34% response rate (total of 524 responses).

**Learning, continuous improvement and innovation**
Evidence appendix United Lincolnshire Hospitals NHS Trust

Staff we spoke with told us that they had not been able to regularly take time out to work on improvements and innovation; however, they felt optimistic about the work in progress related to ward accreditation and quality improvement facilitated by the quality matrons.

**Surgery**

**Facts and data about this service**

Grantham and District Hospital is a small Hospital with 96 funded beds which could be escalated to 114 beds. It forms part of the United Lincolnshire Hospitals NHS Trust formed in April 2000 by the merger of three acute Hospital trusts across Lincolnshire. The trust is one of the largest in the country serving a population of 700,000 people.

The surgical unit at Grantham and District Hospital comprises a 28-bed ward, four theatres, two with laminar flow and a day ward, which has mixed access to surgical and medical patients. Surgery carried out at the Hospital includes low risk elective general surgery and elective orthopaedic knee and hip replacements. It also undertakes trauma surgery for fractured neck of femur.

Details of the surgical wards are shown below:

**Grantham and District Hospital**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Specialties provided</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 2</td>
<td>Trauma and orthopaedics</td>
<td>28</td>
</tr>
<tr>
<td>Day Ward</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

For the period August 2016 to July 2017, the trust had 46,974 surgical admissions. Emergency admissions accounted for 13,731 (29.2%), 26,231 (55.8%) were day case and the remaining 7,021 (14.9%) were elective.

For the period January 2017 to December 2017 Grantham and District Hospital completed a total of 4606 in-patient surgical procedures, 2655 general surgical and 1951 orthopaedic.

The average length of stay for elective surgery for the period October 2016 to September 2017 was 2.4 days, which was lower than the England average of 3.3 days. For non-elective surgery, the average length of stay was 5.8 days, higher than the England average of 5.0 days. *(Source: Hospital Episode Statistics)*

**Is the service safe?**

**Mandatory training**

The trust set a target of 90% for completion of the majority of mandatory training however, some modules had a higher target as presented in the table below.

A breakdown of mandatory training compliance for the period April 2017 to October 2017 for medical/dental staff within surgery is shown below:
Grantham and District Hospital – medical/dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>38</td>
<td>38</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>35</td>
<td>38</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>34</td>
<td>38</td>
<td>89%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>33</td>
<td>38</td>
<td>87%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>33</td>
<td>38</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>33</td>
<td>38</td>
<td>87%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>32</td>
<td>38</td>
<td>84%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>31</td>
<td>38</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>29</td>
<td>38</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>27</td>
<td>38</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>23</td>
<td>38</td>
<td>61%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>TBC</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The trust’s target was not met for 10 out of the 11 mandatory training modules for medical/dental staff at Grantham and District Hospital.

Doctors told us, where possible, mandatory training was online with the more practical elements being classroom-based, for example; basic life support (BLS). Practical training was difficult to roster into the working week. However, identified training needs were included in departmental audit days. Mandatory training was monitored through appraisals.

Junior doctors had dedicated time for completion of mandatory training during their initial foundation year one as part of their induction programme. However, senior house officers (SHOs), registrars and consultants completed training in their paid CPD time.

A breakdown of mandatory training compliance for the period April 2017 to October 2017 for qualified nursing and health visiting staff in surgery is shown below:

Grantham and District Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>51</td>
<td>51</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>51</td>
<td>51</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>51</td>
<td>51</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>50</td>
<td>51</td>
<td>98%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>50</td>
<td>51</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>50</td>
<td>51</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>49</td>
<td>51</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>49</td>
<td>51</td>
<td>96%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>47</td>
<td>51</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>45</td>
<td>51</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust's target was not met for three out of the 11 eligible training modules for nursing and health visiting staff at Grantham and District Hospital.

We were shown how staff accessed online training by 'smart card'. This enabled individuals to access their personal training record. Training requirements were colour coded, for example, amber for training required and red for training expired. Staff told us they were usually able to access the online system and had time within their working day to complete the required training. However, over the winter period this had been limited. Managers were able to monitor compliance with mandatory training through the electronic staff records and the staff appraisal system.

Within the theatre department, the manager had a display board in the office, which clearly indicated any outstanding training. Identified practical training needs took place on audit days.

In addition to the topics listed in the table above, staff received training in sepsis management, Mental Capacity Act 2005 (MCA), deprivation of liberty safeguards (DoLs), safeguarding and dementia awareness. Staff spoken with assured us they had completed or were allocated time to complete all of their training requirements. In recent weeks poor weather had resulted in cancelled training sessions, these were being rescheduled.

### Safeguarding

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training for the period April 2017 to October 2017 for medical/dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>31</td>
<td>38</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>31</td>
<td>38</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>31</td>
<td>38</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>31</td>
<td>38</td>
<td>82%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>8</td>
<td>12</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for safeguarding training for the period April 2017 to October 2017 for qualified nursing and health visiting staff in urgent and emergency care is shown below:
Grantham and District County Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>50</td>
<td>51</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>50</td>
<td>51</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>50</td>
<td>51</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>50</td>
<td>51</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all safeguarding training modules for which qualified nursing and health visiting staff were eligible at Grantham and District Hospital.

The trust had a Safeguarding Adult Policy, revised in 2016, this was accessible to staff through the trust intranet. The policy covered all safeguarding requirements and included guidance relating to topics such as female genital mutilation (FGM). We saw displays in wards and departments, raising the awareness of safeguarding and action to take if required. There was a named safeguarding lead and department displays included how to contact the safeguarding team. Staff understood safeguarding and could explain what they would do if they suspected any form of abuse. The director of nursing had executive oversight of safeguarding for the trust.

At our last inspection in 2016, there was a lack of understanding by some staff of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007). These subjects were now included in the trust key learning and following discussions with staff; we were reassured of an improved awareness of these topics.

**Cleanliness, infection control and hygiene**

The surgical areas inspected were visibly clean, tidy and free from clutter. We saw completed cleaning checklists in all areas.

Cleaning equipment was available and colour coded in line with infection control guidance, to avoid cross contamination between clinical and non-clinical areas. A laminated poster provided information relating to the appropriate coloured equipment required.

Pre-operative assessment staff screened patients through comprehensive questionnaires, interviews and swabbing for a range of potential infection risks. This included methicillin-resistant staphylococcus aureus (MRSA), methicillin-susceptible Staphylococcus aureus (MSSA) and contact with infections such as tuberculosis (TB) influenza (Flu) and *clostridium difficile* (*C. difficile*). The trust had guidelines for the management of patients with *C. difficile* guidelines for the control of MRSA and MSSA infection prevention surveillance meetings were held monthly.

For the period, 1 April 2017 to 15 March 2018 there was no reported community or Hospital acquired MSSA and one Hospital acquired case of *C. difficile* reported by Grantham and District Hospital.

There was personal protective equipment (PPE) in the form of gloves and aprons readily available in all departments. We observed staff using and disposing of these between patients. Additionally, hand-cleansing gel was available at the entrance and throughout each area visited; we saw staff and visitors using the cleansing gel.
Surgical wards and the operating department completed hand hygiene audits each month. Displays indicated 100% compliance in all departments for January / February 2018.

All clinical staff noted to be bare below the elbow in line with infection prevention and control guidance for good practice.

Within the operating theatres staff changed from their own clothes into ‘scrubs’, cotton trousers and tunics, on arrival to the department. Staff wore paper hats to cover their hair; these were colour coded to indicate a person’s role. For example, as visitors, we were provided with yellow hats.

Recording surgical site infection (SSI) rates within orthopaedic surgery became compulsory in 2006. The trust’s director of infection control annual report 2016-17 (DIPC) states all compliance requirements were met. Public Health England (PHE) data for the period January 2017 to March 2017 shows a SSI rate for Hip and knee replacements at Grantham and District Hospital of less than 1%.

Surgical instruments and procedure packs were sterilised by an external commercial provider. These were delivered daily using an ‘in-time’ system. This prevented long-term storage, reduced storage requirement and the risk of packaging damage and subsequent de-sterilisation. Any damaged packs were returned for re-sterilisation. All packs were stored on racking above floor level.

Flexible endoscopes were sterilised through the commercial provider.

Within theatres, screening curtains were disposable and labelled as anti-microbial / anti-sporicidal. All curtains looked at had been changed between November 2017 and January 2018. Staff told us replacements were readily available should contamination by blood or other body fluids occur. However, on the surgical ward we saw curtains without a replacement date in two bays and three curtains, which were past their replacement date. We escalated this to the nurse in charge who arranged for the curtains to be changed. On return to the ward 48 hours later, the curtains had been replaced.

Clinical waste was bagged, sealed and segregated in preparation for twice-daily collection.

We observed staff cleaning patient observation trolleys and other equipment, for example commodes between patients; cleaned equipment had green ‘I am clean stickers’. An audit of commodes in 2016 had identified one of four commodes on ward two was found to be soiled. During our visit, all commodes appeared to be clean and had ‘I am clean stickers’.

There was a trust wide policy for sepsis management. Staff were trained as part of the trust’s key learning programme, which included all aspects of the Sepsis Care bundle and Sepsis 6. Sepsis 6 is a bundle of medical therapies designed to reduce the mortality of patients with sepsis. A labelled Sepsis 6 box containing the basic supplies required to commence treatment of suspected sepsis was stored alongside the emergency resuscitation trolleys.

The dirty utility room on ward two had a biohazard spillage kit, in which packaging seals were broken. We escalated our finding to the nurse in charge who arranged replacement of the kit.

Environment and equipment

All equipment storage areas were tidy with equipment being accessible for use when needed. Equipment in regular use, for example observation trolleys, which included electronic blood pressure machines, heart rate, oxygen saturation and digital thermometers, were within the ward areas. We saw equipment had stickers indicating when service was required.
There was a trust wide in-house medical physics equipment and calibration service. Staff told us they had not experienced difficulties accessing equipment required to carry out their duties. We saw equipment was labelled indicating service dates. However, on the surgical ward we identified several items of equipment with expired service dates. We escalated this to the nurse in charge who reported the issue immediately. On return to the ward, all equipment was checked or had been removed awaiting service.

The operating theatres had recently been refurbished and appeared visibly clean with clear, uncluttered work surfaces.

We reviewed resuscitation trollies in the ward and operating department. Records showed staff signed daily checks for emergency equipment, in line with trust policy. Additionally, within the operating department specialist emergency equipment such as a difficult intubation trolley (difficult airway access) were seen to be easily accessible and checked daily. Other equipment, for example anaesthetic machines and diathermy equipment had been checked and serviced.

We saw equipment had been cleaned between patients and stored with a green ‘I am clean’ sticker to indicate readiness for use.

Wards and departments hold regular morning team briefs known as ‘huddles’ which included sharing product and safety alerts. We saw recorded notes of ‘huddles’ on display for staff not on duty. Information documented included equipment updates, recalls, shortages and items removed for repair.

Grantham and District Hospital had elective admission exclusion criteria, which excluded patients with a body mass index (BMI) of above 35. Therefore, there was limited equipment available for the larger patient. However, we were informed commodes and larger chairs were available within the Hospital if required.

We observed appropriate segregation of clinical and non-clinical waste and correct storage of controlled substances hazardous to health (COSH). Laminated information posters provided guidance on correct management of COSH and waste disposal.

There was separate male/female toilet and washing facilities on the ward. All had equipment available to raise the level of the toilet seat.

Assessing and responding to patient risk

All patients had a comprehensive pre-operative risk assessment. This was documented in an acute in-patient risk assessment booklet, which included patient medical history and health questionnaire, plus a range of risk assessments including; malnutrition universal screening tool (MUST), body map and pressure ulcer risk (Waterlow), body mass index (BMI), bed rail requirement, falls risk, mental capacity and hip and knee score for those undergoing joint replacement. We reviewed five patient records and found all assessments had been completed prior to or on admission for surgery.

Nursing staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores enable early recognition of a patient deterioration by grading the observations and prompting nursing or medical reviews at specific trigger points. The NEWS score was electronically displayed on the ward providing a visual prompt for when observations were due and highlighting those with elevated scores. We saw staff reviewing the electronic board and completing observations in a timely way. We also reviewed five patient observation charts and found them to be completed and scored correctly.
The pre-assessment clinics worked closely with surgeons and anaesthetists and were able to see patients in clinic following a decision to operate. An anaesthetist was present in pre-assessment one day per week to assess the suitability of patients with multiple co-morbidities (other medical conditions) to undergo surgery at Grantham and District Hospital. Specialist nurses were able to initiate blood screening and request blood transfusions, if required. Staff told us they always had access to specialist advice and anaesthetists responded promptly to emails. However, they felt the service would benefit from increased anaesthetic attendance within pre-assessment.

In the operating department, we observed use of the World Health Organisation (WHO) surgical safety checklist. The WHO is a simple checklist developed by the World Health Organisation, which reduces surgical risk through a series of checks, including confirming the patient's identity, operation site, procedure and consent. It also included identification and dedicated role of all staff present. We followed a patient from arrival in theatre through to recovery and noted all checks were completed appropriately. The completed WHO checklist was included in each patient’s anaesthetic and surgical record booklet.

The operating department at Grantham and District Hospital complied with the five steps to safer surgery as recommended by the national patient safety agency (NPSA) 2010. This includes team-briefing, sign in, time out, sign out and debriefing. The aim of the five steps to safer surgery was for teams to work collaboratively together to ensure patient safety.

During our previous inspection in 2015 assessing and responding to sepsis was identified as an area for improvement. The trust had launched a sepsis bundle in April 2016, providing clear guidance to front line staff on detection and treatment of suspected sepsis. We saw staff were using the national early warning system (NEWS) as part of their patient observations. NEWS provides a numerical score to observations, for example temperature, blood pressure, pulse etc. to indicate the need to escalate when a patient is at risk of or deteriorating.

Blood transfusion was through the national blood transfusion service based in Sheffield. Finger print technology had been introduced for access to the blood fridge. We did not observe the collection and administration of any blood products during our inspection.

Patients requiring support with mental health conditions at Grantham and District Hospital could be referred to a mental health crisis team through their consultant. Staff told us they had not identified a need for this in their day-to-day work. In addition, there was an established dementia care bundle and we saw a display on the surgical ward with advice and contacts to assist in the support of those living with dementia.

Whilst on the surgical ward we saw staff respond immediately to an emergency call bell.

**Nurse staffing**

Grantham and District Hospital reported their registered nursing staff numbers, as of October 2017, as shown below.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>51.2</td>
<td>43.8</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing)*

From November 2016 to October 2017 Grantham and District Hospital reported a vacancy rate of 12.1% (7.4 WTE) for nursing and midwifery staff within surgery. This was above the trust target of 11.5%. However, the staff turnover rate for November 2016 to October 2017 was below target with only one leaver for the reported period.
From November 2016 to October 2017 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 6.6% for qualified nursing and health visiting staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. Grantham and District Hospital has a turnover rate below the trust target as indicated below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>1.0</td>
<td>20.0</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Senior managers at Grantham and District Hospital told us recruitment across the trust was a continual on-going process. Cohort recruitment was in place for newly qualified staff. However, Lincoln County Hospital attracted the highest number. The trust had encouraged healthcare assistants to undertake NVQ training to enable them to apply for associate practitioner roles within the Hospital.

Within the operating theatres there was 40 WTE staff covering a range of grades, which included nursing and operating department practitioners. At the time of the inspection, there was one band six vacancy. The daily establishment included an on-call team to cover out of hours requirements. The theatre manager told us this team was utilised most days which put pressure on the workforce as staff were required to have eleven hours ‘down time’ between shifts. We were told a change to a three-shift pattern had been considered. However, the WTE establishment was not sufficient to facilitate this.

There had been success with overseas recruitment where teleconferencing had enabled international interviews to take place. This had proved particularly successful in recruiting doctors from abroad. The Hospital supported overseas employees through local social media applications and support groups.

Managers told us staff employed at Grantham and District Hospitals were very loyal, often local and stayed for many years. However, local healthcare reviews and the loss of some services meant staff felt vulnerable with regard to service and job security.

**Sickness rates**

From October 2016 to September 2017 Grantham and District Hospital reported a sickness rate of 5.3% for nursing staff in surgery. This was above the trust's target rate for sickness of 4.5% and was the highest rate in comparison to the other three trust sites.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>4.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>3.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Sickness)
Bank and agency staff usage

Managers told us very few agency staff were employed by Grantham and District Hospital with substantive staff filling vacant shifts through the Hospital bank system. There was an induction checklist for staff unfamiliar with the Hospital for completion prior to the commencement of a shift.

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 11.5% with a further 2.6% of shift remaining unfilled. A breakdown by staff type and location is shown below:

### Grantham Hospital

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>93 (0.9%)</td>
<td>220 (2.0%)</td>
<td>43 (0.4%)</td>
<td>10,935</td>
</tr>
<tr>
<td>Unregistered</td>
<td>0</td>
<td>163 (2.3%)</td>
<td>68 (1.0%)</td>
<td>7,128</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Nursing bank agency)

Medical staffing

Grantham and District Hospital reported their medical and dental staff numbers, as of October 2017, as shown below.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>53.0</td>
<td>47.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

Vacancy rates

From November 2016 to October 2017 Grantham and District Hospital reported a vacancy rate of 14.9% for medical and dental staff in surgery.

Medical and dental vacancies at Grantham and District Hospital was higher than the trust target of 12.0% and the highest level across the four trust sites.

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>12.0</td>
<td>14.9</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>12.0</td>
<td>9.3</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>12.0</td>
<td>9.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>12.0</td>
<td>14.2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Vacancy)
Turnover rates

From November 2016 to October 2017 Grantham and District Hospital reported an annual turnover rate of 10.4% for medical and dental staff. The trust’s turnover rate for medical and dental staff by site for the period November 2016 to October 2017 is shown below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>3</td>
<td>20.0</td>
<td>10.4</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>9.6</td>
<td>20.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>0.0</td>
<td>20.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>11</td>
<td>20.0</td>
<td>15.0</td>
</tr>
</tbody>
</table>

The turnover rate for all sites was within the trust’s target of 20% for an individual staff group.

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

Sickness rates

From October 2016 to September 2017 Grantham and District Hospital reported a sickness rate of 1.6% for medical and dental staff in surgery. This is below the trust’s target rate for sickness of 4.5% and reflected the trust average of 1.4% for this staff group.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>4.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

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

Bank and locum staff usage

Information provided by the trust indicated there had been a steady increase in medical locum expenditure over the period April 2016 to March 2017. We spoke with one locum doctor who said the support for non-substantive medical staff at Grantham and District Hospital was good and they were made to feel like 'one of the team'.

Grantham and District Hospital had a designated clinical director who worked closely with consultants in substantive or locum positions at this location.

Consultant ward rounds were held twice a day and staff told us they had not experienced problems getting medical support when needed.

Staffing skill mix

As of August 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher.
Staffing skill mix for the whole time equivalent staff working at United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>31%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>9%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)

Records

Patient records were in paper format and stored in locked cabinets on the wards, with coded access. We saw staff removing and replacing patient records and ensuring the doors were locked when not attended. We did not see records left where they could be seen by non-health care personnel, ensuring patient confidentiality.

We reviewed five sets of patient notes. These were in good condition with information filed in a logical order. Written statements were signed and dated although not consistently on each page. A Medical record keeping audit 2017 within general surgical Grantham had identified this as an area where standards had not been met. We were therefore not confident this practice had improved.

We saw where investigations had been requested, completed and reported in a timely manner. For example, magnetic resonance imaging (MRI) was consultant reviewed and reported within 24 hours. This was clearly documented within the patient’s notes.

There was documentary evidence of relevant communication with other health professionals and the records reviewed included clear reference to patient’s allergy risks and included an evaluation of the criteria for discharge and recovery. This met clinical guidance in accordance with national institute for health and care excellence (NICE).

We did not see any patient records who were ‘end of life’ or who had do not attempt cardio pulmonary resuscitation (DNACPR) documentation.

The safety and quality dashboard for Grantham and District Hospital November 2017 indicated 100% compliance with required documentation for risk assessments including bed rail requirement, falls risk assessment, pain management, pressure care risk assessment and MUST.

Senior managers reported limited administrative support, which had led to some delays in clinic letters and communication with general practitioners. There was a business case in place to address this with a trajectory of clearing all backlogs within one month.
Medicines

The safety and quality dashboard Grantham and District Hospital surgical ward for November 2017 indicated 100% compliance with medicine storage safety. This included drug cupboards and fridges. We saw medicines were stored in line with legal requirements; however, cupboards were untidy meaning identification of required medicines could be hampered. Additionally, some medicines were out of date. We escalated these to the nurse in charge who immediately addressed the issues. At a subsequent visit to the ward, the out of date medicines had been replaced and the cupboards were tidy.

Daily medicine fridge temperatures were recorded and were consistently within the acceptable 3-8°C range. The room temperature was also monitored and within an acceptable range. Staff told us they would contact pharmacy if a fridge was found to be outside the acceptable temperature range. However, the fridge on ward two did not have an up to date electrical test sticker. This was escalated to the nurse in charge and had been rectified when we revisited the ward.

Medicines to take home (TTO’s) were contributory to some delays for patients waiting to go home. We spoke to a pharmacist who explained there was a shortage of pharmacists to meet demand. Wards were required to request TTO’s in advance of discharge, preferably the day before or on the morning of discharge. However, this was not always achieved.

The trust had an antibiotic protocol, which was available on the trust intranet. A doctor told us this was easily accessible and microbiologist advice was available by telephone. We saw evidence of microbiology advice requests, documented in patient’s notes.

Controlled drugs were stored in line with legal requirements and stock levels were checked and recorded as correct each day. We checked this on the ward and found records to be accurate. Additionally, we observed the administration of a controlled drug, which met the trust medicines administration policy requirements.

Day case surgery safety and quality dashboard reported 100% compliance in all areas audited.

We reviewed five prescription charts and found them to have been reviewed by a pharmacist; all items had been signed as given, or identified as omitted. Instruction, for example antibiotics for three days only was included.

Incidents

Incidents were reported using an electronic reporting system which staff told us, they were able to access and complete easily.

There had been no reported never events at Grantham and District Hospital in the twelve months January 2017 to December 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. However, from January 2017 to December 2017, the trust reported one incident classified as a never event for surgery. This was a retained foreign object post procedure.

We discussed two serious incidents, which had been reported within surgery at Grantham and District Hospital during the period January 2017 to December 2017 with a senior nurse. One was the administration of a wrong medication, and one was the development of a grade 3 pressure ulcer. Both were reported under the criteria set by NHS England and investigated in accordance with the trust incident reporting policy. Lessons learnt were shared with staff at their daily huddle.
and we saw evidence displayed in the ward office of issues discussed. Grantham and District Hospital reported eight SI’s in total during the period January 2017 to December 2017. Two of these related to surgical service.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Total incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>2</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>VTE meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Matrons reviewed all reported incidents. The head of nursing and clinical director reviewed all incidents categorised as moderate or severe.

Staff were able to describe the principle of being open and honest, when things go wrong. However, not all staff were familiar with the term duty of candour. However, we did see where duty of candour had been followed in the incidents we reviewed. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of ‘notifiable safety incidents’ as defined in the regulation. This included giving them details of the enquiries made, as well as offering an apology.

**Safety thermometer**

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

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

Data from the Patient Safety Thermometer showed that the trust reported 49 new pressure ulcers, 31 falls with harm and 9 new catheter urinary tract infections from November 2016 to November 2017 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at United Lincolnshire Hospitals NHS Trust**

![Graph showing prevalence rate of pressure ulcers, falls and catheter urinary tract infections over time]
The rate of pressure ulcers recorded in the Patient Safety Thermometer had varied over time but there had been no upward or downward trend over the period. The rate of falls recorded had fallen over the period and the rate of urinary tract infections in patients with a catheter (CUTIs) had remained similar.

From discussion with the pre-assessment team and reviews of medical notes, we saw patients were risk assessed for veno-thrombo embolism (VTE) and given prophylactic anti-coagulation if required. Patients were also fitted with antithrombotic stockings. An audit in August 2017 indicated 100% compliance with VTE risk assessment and prescription of prophylaxis. However, the audit identified not all patients were given advice on discharge. We saw examples of leaflets now given to patients at pre-assessment.

Senior management told us patient falls were monitored closely, as the estate was old giving rise to possible trip hazards. This was included on the risk register.

The trust had a major incident plan (July 2016) which included action cards for specific roles overseen by a designated gold command. Senior managers knew what was required of them in a major incident situation.

Is the service effective?

Evidence-based care and treatment

The surgical service at Grantham and District Hospital provided care to patients based on national guidance including National Institute for Health and Care Excellence (NICE), Royal College of Surgeons (RCC), Association of Anaesthetists of Great Britain and Ireland (AAGBI). These were supported by local guidelines and policies. Compliance was measured through local and national audits and through presentation to the quality governance and patient safety meetings.

Staff had access to the trust intranet where all policies, protocols and procedures were stored. We saw examples of the policies available. However, we asked to see a copy of an infection control clinical guideline and were shown a document, dated 2008, for women and children’s surgery. We pointed out the document was ten years out of date and the nurse told us the intranet had up to date guidelines. We were not therefore assured the most recent guidelines were being utilised.

The adult in-patient risk assessment booklet included a range of national guidance information to assist staff to provide up to date care. This included pressure ulcer recognition, stool chart and
nutritional assessments. We reviewed five sets of medical/nursing notes and all appropriate risk assessments were completed.

Nutrition and hydration

Patients attending Grantham and District Hospital for surgery were provided with information both verbally and through leaflets about their nutritional and hydration needs prior and post-surgery. This included instructions relating to the period of time they needed to be nil-by-mouth prior to anaesthesia, which was variable depending on the planned procedure and time of day the procedure was to be carried out. Patients spoken with told us the information was clear and if delays had occurred they were offered clear water to drink.

Fresh water was available on the wards and water jugs changed twice a day. There was a choice of hot meals and sandwiches provided for in-patients and patients said they were of good quality. Special diets were catered for, such as diabetic, low residue and vegetarian.

There was a dietetic service available on referral or on request for patients on special diets.

All patients had a malnutrition universal screening tool (MUST) assessment pre-operatively. We saw evidence of dietary needs and nil-by-mouth times recorded in patient notes.

Pain relief

Pain management was discussed with patients pre-operatively. We saw information was provided at pre-assessment clinic.

We interviewed four post-operative patients who told us staff frequently asked if they were comfortable, had any pain or required pain relief. None of the patients reported difficulty or delays in receiving pain relief.

Additionally, there was hourly ‘rounding’ on the surgical ward. This involved the nurse in charge visiting each patient hourly to ask about concerns or needs, including ‘did they have any pain’. We saw documentary evidence of this.

The safety and quality dashboard reported 100% compliance with pain management for the surgical ward areas.

Patient outcomes

There were a number of local and national clinical audits, as outlined below.

Relative risk of readmission, trust level

From September 2016 to August 2017, the trust had a lower than expected relative risk of readmission for elective admissions when compared to the England average. However, when comparing the trust to the England average at specialty level (for the most common three specialties at the trust) Trauma & Orthopaedics patients had a higher than expected relative risk of readmission for elective admissions.

The trust had a lower than expected relative risk of readmission for non-elective admissions when compared to the England average. For all of the three most common specialties at the trust the relative risk of readmission for non-elective patients was lower than the England average.

Elective Admissions – Trust Level
Evidence appendix United Lincolnshire Hospitals NHS Trust

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

Non-Elective Admissions – Trust Level

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

Grantham & District Hospital

From September 2016 to August 2017, Grantham & District Hospital had a lower than expected relative risk of readmission for elective admissions when compared to the England average. However, when comparing the Hospital to the England average at specialty level (for the most common three specialties at the Hospital) Urology patients had a higher than expected relative risk of readmission for elective admissions. Senior managers considered this outcome measurement to be reflective of the number of urology patients returning to the Hospital for associated post-operative treatment.

Elective Admissions - Grantham & District Hospital

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

**Hip Fracture Audit**

**Grantham and District Hospital**

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.2%, which was within the expected range. The 2016 figure was 5.7%.

Seventy six percent of patients had surgery on the day of or day after admission, which was above the England average of 72%. However, this was below the 2016 average of 79%.

Nutritional assessment was reported as 38% with an England average of 86%. However, patient’s records reviewed on our inspection included a MUST nutritional assessment.

The perioperative medical assessment rate was 56.4%, which falls in the bottom 25% of all sites that participated in the audit. However, this was an improvement on the 2016 audit of 34.8%. A consultant ortho-geriatrician had recently been appointed.

80.8% of patients were documented as not developing a pressure ulcer, which put the Hospital in the bottom 25% of all sites that participated in the audit. The 2016 figure was 90.8%.

The length of stay was 16.2 days, which falls in the top 25% of all sites that participated in the audit. The 2016 figure was 16.4 days.

In the Patient Reported Outcomes Measures (PROMS) survey, patients were asked whether they feel better or worse after receiving the following operations: Groin Hernias, Varicose Veins, Hip or knee replacements.

The proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17, the proportion of groin hernia patients who reported an improvement following surgery was similar to the England average.

The trust performed worse than the England average for the proportion of patients who reported an improvement or a worsening following surgery for hip replacements, knee replacements and varicose veins.

Morbidity and mortality rates were presented and discussed at clinical governance meetings and at grand rounds for sharing and learning purposes.

**Competent staff**

This information is routinely requested within the universal provider information request.

Staff were competent and appropriately trained to undertake the role for which they were employed and had equal opportunities for professional development.

The trust provided appraisal rates for staff requiring appraisal for the period April 2017 to October 2017. As most appraisals are carried out at the end of the financial year, figures do not include all staff members. From April 2017 to October 2017 419 staff were required to complete an appraisal with 83.5% of these having received an appraisal. This was lower than the trust target of 85%.

Data for the period April 2017 to October 2017 relating to 206 Grantham and District Hospital surgical staff showed an appraisal rate of 79.5%. This did not meet the trust target of 85%. However, medical and nursing staff at Grantham and District Hospital told us they had completed or had dates pending for their appraisals. Additionally, we saw evidence of appraisal monitoring at departmental level. Staff spoken with told us their appraisals had been useful and included realistic objectives.
A split by staff group can be seen in the graph below:

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

The trust had an Induction and Core Learning Training Policy, January 2015. The document included core learning needs analysis, which outlined staff groups, initial training, refresher training, duration and methodology (Classroom/e-learning), required update period, additional requirements and accreditation status. Additionally, the policy includes a standard operational policy for agency nurse induction and checklist. We saw an example of the checklist.

Volunteer staff employed at the trust undergo a recruitment process, which mirrored the requirements for all other Hospital staff (application form, disclosure and baring system checks and two references). There was an induction checklist.

Medical staff had an annual budget for training / conference attendance to support their professional development. Nursing staff were required to apply to the trust for access to training or conference attendance. However, nurses told us there were limited resources to support their application. The head of nursing told us funding was available and requests were reviewed based on relevance and equality of access for all nursing staff.

We saw evidence of planned training sessions for medical staff and ‘grand rounds’ where cases are presented and discussed for sharing and learning. We spoke with a junior doctor who was on a three-month rotation to Grantham and District Hospital surgical department who told us; ‘the department worked closely together, was very supportive, promoted learning and all staff contributed to audit days’.

Audit days are compulsory and attended by medical and nursing staff. They are organised at departmental level to address mandatory and specialist training needs.

Qualified nurses spoken with told us there was support provided for registration revalidation.

**Multidisciplinary working**

Multidisciplinary working was evident with staff describing good collaborative working across multi professional teams. Examples included working with medical staff, allied health professionals
(AHP) and the infection prevention and control (IPC) team. This was particularly evident within pre-assessment where staff engaged with a wide range of professionals.

During our inspection, we saw there was consultant-led multidisciplinary ward rounds. We saw treatment plans documented in the patient records we reviewed. For example, occupational therapists, physiotherapists, dietitians and speech and language therapists (SALT) documented patient progress within the patient care record. This enabled a joined-up approach to assessment of patients' needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

Information about patients’ Hospital admission including treatment, care undertaken and prescribed medicines was sent electronically to their GP on discharge. Patients were also given a paper copy to take home.

Nursing and medical staff told us they had a positive relationship with the pharmacy team, who they described as approachable, accessible, and knowledgeable.

**Seven-day services**

Surgery was carried out over five days at Grantham and District Hospital with the operating department opening from 08:00 hours through to 17:30 hours. An on-call team was rostered each day to cover additional hours. The theatre manager told us the on-call team was utilised most days.

We reviewed five sets of patient medical notes and all of them showed evidence of a clinical review from a consultant within 12 hours. This was in line with priority clinical standard two, review within 12 hours.

Pharmacy services were available between Monday and Friday 9am to 5pm and Saturday 9am to midday. There was an on-call pharmacy team provided out of hours.

Physiotherapy was provided seven days a week and included on-call and out of hour’s services.

Occupational therapy services were available five days a week.

**Health promotion**

Information leaflets for all surgical procedures carried out at Grantham and District Hospital were available and given to patients at pre-assessment clinic. These leaflets included how to ensure patients were in the best health possible prior to admission to Hospital. This included advice on diet and exercise.

Additionally, alcohol and smoking cessation information was available for patients. However, the trust did not provide smoking cessation products to patients.

Larger patients (Bariatric) were referred to Lincoln County Hospital for dietetic advice and surgery.

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

We reviewed five sets of medical notes and found consent forms had been completed in line with trust consent policy and General Medical Council, Good medical practice guidance.

An audit of surgical consent at Grantham and District Hospital 2017 showed compliance with required standards with the exception of recording the doctors job title, patient gender and provision of information leaflets. We found these requirements had been included in the notes reviewed.
Deprivation of Liberty safeguards training at the trust was completed as part of the Mental Capacity Act (MCA) level 2 training module.

The trust set a target of 90% for completion of MCA level 2 training. A breakdown of compliance for MCA level 2 training for medical and dental staff in surgery for the period April 2017 to October 2017 is shown below:

**Grantham and District Hospital – medical and dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>30</td>
<td>38</td>
<td>79%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Grantham and District Hospital – Qualified nursing & health visiting staff (Qualified nurses)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>48</td>
<td>51</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Grantham and District Hospital met the trust target for MCA level 2 training compliance with 94% of staff having completed the training.

There was an understanding of the Mental Capacity Act (MCA) across all staff groups. We saw information displayed in departments, which included reference to MCA and access to support with mental health, for example as part of the dementia care bundle. Staff completed MCA assessments for all patients admitted.

**Is the service caring?**

**Compassionate care**

The Friends and Family Test (FFT) response rate for surgery at United Lincolnshire Hospitals NHS Trust was 27%, which was similar to the England average of 29% for December 2016 to November 2017. Grantham and District Hospital had the highest response rate when compared to the rest of the trust at 83%. Responses were positive across all areas for the surgical wards at Grantham and District Hospital; this reflected the comments received from patients during the inspection. All patients we spoke with told us they were very happy with the care and treatment received at the Hospital was clean and the food very good. Relatives visiting post operatively told us information given prior to the operation was excellent.

All observed interactions between staff, patients and carers appeared compassionate with time provided for listening and responding to questions asked. Patients and carers told us staff were kind and helpful.
Friends and family test response rate at United Lincolnshire Hospitals NHS Trust, by site.

![Bar chart showing percentages of patients recommending the hospital to friends and family.

The percentage of patients that would recommend the Hospital to friends and family is split by ward below:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total Resp</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Hospital Louth</td>
<td>185</td>
<td>55%</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Grantham &amp; District Hospital</td>
<td>252</td>
<td>83%</td>
<td>100%</td>
<td>55%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>983</td>
<td>25%</td>
<td>55%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>1,566</td>
<td>25%</td>
<td>55%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>This trust</td>
<td>448</td>
<td>27%</td>
<td>55%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>England Avg</td>
<td>5,216</td>
<td>29%</td>
<td>55%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England Friends and Family Test)

Emotional support

From the operating department patient reception, we accompanied a patient through their journey into recovery and transfer to the ward. The procedure to be carried out was described and ample time to ask questions was provided. Staff demonstrated empathy towards the patient, holding their hand, reassuring them and accompanying them to the anaesthetic area. Within theatre recovery, the patient was given lots of reassurance.

Ward nurses were observed taking time to talk to patients, offer assistance and reassure both patients and visitors as needed. We observed a nurse offering support to a family of a confused patient who were clearly distressed by their behaviour.

There was advice and support available for patients and carers living with dementia and we saw displays on the ward, which included useful contact numbers.

Understanding and involvement of patients and those close to them

Patients told us all their treatment had been explained and they were encouraged to ask questions. We spoke with a parent of a young adult, who told they had been given all the...
information required including a direct contact number and had been allowed to visit out of designated visiting time immediately after surgery.

There was information on the wards for patients and carers and we saw family members being actively encouraged to be involved in their loved ones recovery. This included assistance with meal selection, encouraging mobility and assisting with personal care.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Grantham and District Hospital was able to meet the local demand for surgery with many patients opting for surgery at this site, in preference to travelling to other sites within the trust. However, due to limited enhanced care options, the Hospital had exclusion to surgery criteria. This provided guidance for assessing patients with co-morbidities (other medical conditions) who may be at greater risk of complications. We saw the exclusion protocol effectively used at pre-assessment.

**Average length of stay**

**Trust Level – elective patients**

For the period October 2016 to September 2017, the average length of stay for all elective patients at the trust was 2.6 days, which was lower than expected compared to the England average of 3.3 days.

When split by specialty the average length of stay for all three of the most common specialties (based on count of elective activity) at the trust was similar to the England average.

**Elective Average Length of Stay – Trust Level**

![Elective Average Length of Stay – Trust Level](image)

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

**Trust Level – non-elective patients**

The average length of stay for all non-elective patients at the trust was 5.2 days, which was similar to expected when compared to the England average of 5.0 days.

When split by specialty the average length of stay for two of the three most common specialties (based on count of non-elective activity) at the trust was similar to the England average. These were General Surgery and Urology. The average length of stay for non-elective Trauma and Orthopaedics patients was 7.3 days, which was lower than the England average of 8.9 days.

**Non-Elective Average Length of Stay – Trust Level**

![Non-Elective Average Length of Stay – Trust Level](image)
Grantham & District Hospital - elective patients

For the period October 2016 to September 2017, the average length of stay for all elective patients at Grantham & District Hospital was 2.4 days, which was lower than the England average of 3.3 days.

When split by specialty the average length of stay for two of the three most common specialties (based on count of elective activity) at the Hospital was similar to the England average. These were Trauma and Orthopaedics and Urology. The average length of stay for elective General Surgery patients was 1.8 days, which was lower than the England average of 3.3 days.

Non-Elective Average Length of Stay - Grantham & District Hospital

Note: Top three specialties for specific trust based on count of activity.
Meeting people’s individual needs

The pre-assessment process supported the requirement of identifying people’s individual needs. This included a comprehensive health questionnaire, which pre-assessment nurses completed with the patients, providing opportunity to discuss and identify specific needs. This included detailed information about allergies including latex and any medications.

The trust has a ULHT Dementia Care Bundle, which provides guidance to staff on patient assessment and included a medical referral pathway with a named lead for each location.

The trust had two learning disability (LD) nurses who provided advice on request. Additionally, we were told, if a patient with known learning difficulties was attending clinic, an LD nurse would attend, if able to do so.

The trust reported no mixed sex breaches with all ward bays designated as male or female. Additionally, there was access to male and female toilet facilities.

The trust provided an interpretation and translation service available 24 hours a day, seven days a week through a contracted supplier. This service included face-to-face interpreting, telephone interpreting and written translation. Staff we spoke with were aware of this service. Additionally, written translation could be requested.

There was access to a chaplaincy service and a multi-denominational room with 24-hour access.

Access and flow

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

For the period November 2016 to October 2017, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was 56.2% compared to the England average of 69.9%. The trust performed consistently below the England average for Surgery in every month reported.

For the months, October 2017 and November 2017 the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This had been resolved by the trust in the agreed timescales.

Referral to treatment rates (percentage within 18 weeks) for admitted pathways, United Lincolnshire Hospitals NHS Trust

(Source: NHS England)

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

Evidence appendix United Lincolnshire Hospitals NHS Trust
A breakdown of referral to treatment (RTT) rates for admitted pathways in surgery, broken down by specialty is below. All six specialties at the trust performed below the England average for admitted RTT rates.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.7%</td>
<td>77.0%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>61.1%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>57.5%</td>
<td>61.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>47.3%</td>
<td>72.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>45.2%</td>
<td>64.4%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0.0%</td>
<td>83.1%</td>
</tr>
</tbody>
</table>

Senior managers told us they were taking steps to improve RTT. This included a review of all activity, additional outpatient sessions and ad-hoc clinics, the introduction of one-stop clinics and virtual nurse led clinics. The effectiveness of these actions were monitored through a daily report on all 12 week waits, full consultant led harm reviews weekly and designated weekly cancer RTT and risk meeting. To facilitate the time commitment required these actions had been recognised and included within consultant job plans.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in Hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and Hospital of their choice.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - United Lincolnshire Hospitals NHS Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days.](image)

Over the two years 2016 / 2018, the percentage of cancelled operations at the trust showed a declining trend and since quarter, three of 2016 / 17 the trust’s performance had been similar to the England average.

In the most recently reported quarter (Q2 2017/18) 3.8% of the 679 cancelled operations were not treated within 28 days which was lower than the England average of 6.8%.
Over the two years, the percentage of cancelled operations at the trust showed an upward trend, and was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

The senior managers told us over the two months prior to our inspection cancellations had increased. This was due to poor weather and staffing problems. However, readmission within 28 days had improved.

**Learning from complaints and concerns**

For the period October 2016 to September 2017 Grantham and District Hospital received 17 complaints relating to surgical care. However, the trust took an average of 77 working days to investigate and close complaints. The trust had an internal target to close 80% of complaints within 35 days. Of the 17 complaints, 12 had been closed at the time the data was provided and 8.3% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days when taking this target into consideration, 16.7% of all of the closed complaints were closed within 50 days.

Responses were signed off by the clinical director or head of nursing.

The most common themes in complaints at Grantham and District Hospital were delay or failure in treatment or procedure (five), delay in discharge (two) and communication with the patient (two).

Learning from complaints was shared at the morning staff huddles and monitored by the trust quality team.

(Source: Routine Provider Information Request (RPIR) Complaints)
Is the service well-led?

Leadership

Leadership at Grantham and District Hospital was through a clinical director, Head of Operations & Clinical services. Supported by general surgery and orthopaedic heads of service, matron and band seven ward sisters. The range of experience within the senior team enabled effective leadership of the surgical service at Grantham and District Hospital.

Surgical division leadership at trust level had recently entered a period of stability following a two-year period of several changes in general management. This was recognised by senior managers as stabilising in terms of developing the service.

The majority of staff told us they felt local managers were visible, approachable, supportive and they received appropriate support to allow them to complete their jobs effectively. They were able to name the chief executive and trust senior nurse and had seen them at trust meetings or received communication from them. However, they had not seen them at departmental level.

Managers we spoke with were positive about the impact of quarterly multi professional senior leadership forums introduced in 2017. The forum, chaired by the chief executive officer, had improved trust wide communication at a senior level. Additionally, ward sisters had a protected ten minute ‘time to talk session’ where patient safety and current risks could be addressed with fellow managers.

Vision and strategy

The trust had a five-year strategy for all clinical services for 2014 to 2019 to support the delivery of good quality patient care. The vision and strategy for surgical care was to provide comprehensive planned services. Additionally, the trust had a staff and public engagement strategy called ‘Our Ambitions 2021’. This was displayed around the trust.

The trust vision; working together to provide sustainable high quality patient-centred care for the people of Lincolnshire was underpinned by five key values; to be patient-centred, safety, excellence, compassion and respect. During our inspection, we met and spoke with staff in pre-assessment, on the surgical ward and operating theatres who demonstrated the trust’s values by working together to provide a seamless service for patients.

Managers we spoke with outlined plans to meet the vision and strategy for the surgical service at Grantham and District Hospital, increasing through a review of nursing and medical establishments with a view to increase elective and emergency pathways at this site.

Senior managers we met with were able to describe challenges the service was experiencing and actions being taken to support staff through some difficult times. This included recruitment, managing an aging estate and the planned review of services across the trust. They told us they wanted to ‘continue providing a good community service’.

There was a people’s strategy, which sets out a vision for the workforce of the trust. It analyses projected workforce activity and considers, for example the effect of an aging workforce and the need to consider flexibility in order to retain skills and promote the careers of younger people.

Information relating to vision and values was displayed in the departments visited.

Culture

Staff told us they enjoyed working at Grantham and District Hospital and felt valued in their work. They said there was a community spirit and recently staff had put every effort into coming to work despite ‘terrible weather conditions’.
There appeared to be an open relationship between managers at a local level with staff feeling able to discuss their concerns or make suggestions to their line or departmental manager. Staff said they were encouraged to report concerns and incidents and were not afraid to do so. They described an open and honest culture.

**Governance**

From September 2017, the trust had introduced ward accreditation as its approach to measuring the quality of care delivered to patients in the ward environment. There were standard operating procedures in place to support the ward accreditation process with full Trust Board approval gained in June 2017.

The governance structure had been reviewed with monthly governance meetings and quarterly trust-wide meetings established. The trust had appointed additional risk management staff to work alongside departments, audit leads, matrons and the policy group to recognise and raise concerns.

There were four quality matrons working alongside ward sisters. The aim of these positions was to concentrate on quality of care and to support wards through the accreditation process.

**Management of risk, issues and performance**

There was an electronic risk register in place for recording and managing risks. We looked at the risk register during our visit, which included a description of each risk, date of identification, review date, actions, named responsibility and RAG (red/amber/green) status. Risks identified included staffing, estates, capacity and referral to treatment times (RTT) which reflected those identified through our discussions with the senior management team.

From September 2017, the trust had introduced ward accreditation as its approach to measuring the quality of care delivered to patients in the ward environment using multiple methods and sources of data. In total 13 standards were monitored and a rating applied ranging from Red through to Amber and Green to eventually Blue. The ultimate aim was for all acute Hospital wards across ULHT to be rated as Blue. We saw standard operating procedures were formulated to support the ward accreditation process with full Trust Board approval gained in June 2017.

**Information management**

Service performance measures were reported and monitored. The ward managers and matrons had access to a quality and safety dashboard at all times, which displayed performance measures. The information was displayed on ward noticeboards. This meant staff and visitors could see at a glance how well wards were performing.

The trust published annual reports including for example a joint strategic need assessment (JSNA), complaints, equality and diversity, safeguarding and infection control annual report (DIPC). These are available on the trusts public website.

**Staff Engagement**

Surgical wards and operating theatres held team meetings, which were minuted. These provided relevant updates about the department, the division and the wider trust. A staff huddle took place at the beginning of each day for sharing and learning purposes. Staff told us this was a good opportunity to find out what was going on and discuss important issues. Nursing staff spoke
positively of being involved in decisions and new ways of working, we saw evidence from staff meetings where local and trust developments had been discussed.

Trust staff survey 2017 results showed a score of 3.6 with one indicating staff had little engagement and five indicating highly levels of staff engagement. This was slightly down on the 2016 result of 3.75.

The chief executive sent a weekly email to all staff. This included what was happening in the trust, information about national visits, awards given and health information such as the availability of the flu vaccine.

The trust had a ‘staff engagement on 2021’ strategy. The document outlined how staff were being engaged in discussions about the future of United Lincoln Hospitals NHS Trust (ULHT). A survey of staff had established common themes for the trust to consider when developing the 2021 five-year strategy. A key theme was to make better use of workforce, improving recruitment and retention of staff. Additionally, the survey gave an opportunity for staff to put forward ideas which could save money or increase revenue. For example, investment in renewable energy, improve clinical coding (this ensures a trust receives payment for work completed) and reduce waste. The survey indicated 64% of staff who took part knew ‘a little bit’ about the trust five-year plan. However, only 18% were confident the strategy would transform ULHT.

The trust had an annual awards programme to recognise individuals or teams for hard work and contributions to good patient care. Any member of staff can nominate a colleague or team for an award.

**Public engagement**

The trust had a ‘Public engagement on 2021’ strategy to consult with the public and service users about the future of United Lincoln Hospitals NHS Trust (ULHT). The trust had contacted over 110 groups and attended 57 public meetings. The key conclusion was people would prefer services closer to home wherever possible, although people accepted specialist services where the expertise was available. The public understood the current NHS issues including recruitment, finance and safety.

Grantham & District Hospital friends and family survey results showed 87% of patients out of 2,127 who completed the survey would recommend the Hospital to family and friends.

**Learning, continuous improvement and innovation**

The ward accreditation programme was initiated in 2017 at Grantham and District Hospital. Staff were positive about the improvements this would bring. The trust had appointed quality improvement matrons to manage and oversee this project.
County Hospital Louth

Evidence appendix
High Holme Road,
Louth, Lincolnshire, 
LN11 0EU

Tel: 01507 512512
www.ulh.nhs.uk

Surgery

Facts and data about this service

County Hospital Louth is a small hospital forming part of the United Lincolnshire Hospitals NHS Trust formed in April 2000 by the merger of three acute hospital trusts across Lincolnshire. The trust is one of the largest in the country serving a population of 700,000 people.

The trust’s pre-inspection report (PIR) states the surgical unit at County Hospital Louth comprises one ward with 20 physical bed spaces made up of fourteen beds, four reclining chairs and two patient trolleys and an operating department with two theatres. Surgery carried out at the hospital is limited to adult low risk elective general surgery and orthopaedic knee and hip replacements.

For the period January 2017 to December 2017 County Hospital Louth completed 1004 general surgical procedures and 854 orthopaedic procedures.

Details of the surgical wards are shown below:

County Hospital Louth

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Specialties provided</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fotherby</td>
<td>General Surgery</td>
<td>20 bed spaces</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The trust set a target of 90% for completion of the majority of mandatory training however, some modules had a higher target, which can be seen in the table below.

A breakdown of compliance for mandatory training for the period April 2017 to October 2017 for medical/dental staff in surgery is shown below:
Louth Hospital – medical/dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>3</td>
<td>4</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>3</td>
<td>4</td>
<td>75%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>3</td>
<td>4</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>3</td>
<td>4</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>2</td>
<td>4</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>2</td>
<td>4</td>
<td>50%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The trust’s target was not met for 6 out of the 11 mandatory training modules at Louth Hospital. However, due to the small numbers of staff figures can be misleading. For example, all four staff must have completed a training module for the trust target to be met. We spoke with one consultant anaesthetist, one operating department practitioner and one orthopaedic surgeon who told us they were up to date with all mandatory training requirements.

A breakdown of compliance for mandatory training compliance for the period April 2017 to October 2017 for qualified nursing and health visiting staff within surgery is shown below:

Louth Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Awareness</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fraud Awareness</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, Trips &amp; Falls</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic Life Support</td>
<td>18</td>
<td>20</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>18</td>
<td>20</td>
<td>90%</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>18</td>
<td>20</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>15</td>
<td>20</td>
<td>75%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>8</td>
<td>0</td>
<td>N/A</td>
<td>90%</td>
<td>N/A</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>TBC</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Data provided indicated staff had not met the trust’s target for three out of the 11 eligible training modules for nursing and health visiting staff at Louth Hospital.
Staff accessed on-line training by ‘smart card’. This enabled individuals to access their personal record where training requirements were colour coded; for example, amber for training required and red for training expired. Staff told us they were usually able to access the on-line system and had time within their working day to complete the required training. However, over the winter period, this had been limited with some classroom training rescheduled. Mandatory training was monitored through the staff appraisal system. Staff spoken with on Fotherby Ward told us they were up to date with all mandatory training requirements; this was corroborated by training records held on the Ward.

In addition to the topics listed in the table above, staff received training in sepsis management, Mental Capacity Act 2005 (MCA), deprivation of liberty safeguards (DoLs), safeguarding and dementia awareness. Staff spoken with on Fotherby Ward and within the operating theatre assured us they had completed or where allocated time to complete all of their training requirements.

**Safeguarding**

The trust set a target of 90% for completion of safeguarding training. A breakdown of compliance for safeguarding training for the period April 2017 to October 2017 for medical/dental staff in surgery is shown below:

**Louth Hospital – medical / dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all safeguarding training modules at Louth Hospital.

A breakdown of compliance for safeguarding training from April 2017 to October 2017 for qualified nursing and health visiting staff in urgent and emergency care is shown below:

**Louth Hospital – Qualified nursing & health visiting staff (Qualified nurses)**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% target was met for all safeguarding training modules for which qualified nursing and health visiting staff were eligible at Louth Hospital.
The trust had a Safeguarding Adult Policy, revised in 2016, this was accessible to staff through the trust intranet. The policy covered all safeguarding requirements and included guidance relating to topics such as female genital mutilation (FGM). We saw information in staff areas raising awareness of safeguarding and providing useful contact numbers. Staff spoken with understood safeguarding and were able to explain what they would do if they suspected any form of abuse. There was a named safeguarding champion for the surgical unit. Staff were able to name the champion and give examples of when they would raise a safeguarding alert.

The director of nursing had executive oversight of safeguarding for the trust.

Following our previous inspection in 2016, concern about a lack of understanding by some staff of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007). These subjects were now included in the trust key learning and following discussions with staff; we were reassured of an improved awareness of these topics.

Cleanliness, infection control and hygiene

The ward and operating department at Louth Hospital appeared visibly clean, tidy and free of clutter. We saw completed cleaning checklists in all areas.

Cleaning equipment was available and colour coded in line with infection control guidance, to avoid cross contamination between clinical and non-clinical areas. A laminated poster provided information relating to the appropriate colour required.

Preoperative assessment screening took place at County Hospital Louth. This included comprehensive questionnaires, interviews and swabbing for a range of potential infection risks. This included meticillin-resistant staphylococcus aureus (MRSA), meticillin-susceptible Staphylococcus aureus (MSSA) and contact with infections such as tuberculosis (TB) influenza (Flu) and clostridium difficile (C.difficile). Patients with identified risk were referred to Lincoln County Hospital for further assessment.

For the period, 1 April 2017 to 15 March 2018 there was no reported community or hospital acquired MRSA, MSSA or C.difficile reported by County Hospital Louth.

Personal protective equipment (PPE) in the form of gloves and aprons were readily available in the ward and operating theatre. We observed staff, on the ward, using and disposing of these between patients. Additionally, hand-cleansing gel was available at the entrance and throughout each area visited; we saw staff and visitors using the cleansing gel.

Clinical staff were bare below the elbow in line with infection prevention and control guidance for good practice.

In the operating department staff changed from their own clothes into ‘scrubs’, cotton trousers and tunics, on arrival to the department. Staff wore paper hats to cover their hair; these were colour coded to indicate their role. For example, as visitors, we were provided with yellow hats.

The surgical ward and the operating department had completed hand hygiene audits. Displays indicated 100% compliance for the period January / February 2018.

Recording surgical site infection (SSI) rates within orthopaedic surgery became compulsory in 2006. The trust’s director of infection control annual report 2016-17 (DIPC) states all compliance requirements were met. However, public health England (PHE) had not published relevant data prior to publication of the report. Information provided pre-inspection stated no SSI within orthopaedic surgery within the twelve months preceding the inspection.
All screening curtains were disposable and had been changed in the three months prior to our inspection. Disposable curtains should be changed six monthly or if soiled.

Clinical waste was bagged, sealed and segregated in preparation for daily collection.

Patient observation trolleys and other equipment for example commodes appeared clean and had green ‘I am clean stickers’. An audit of commodes in 2016 found all commodes on Fotherby Ward to be clean. During our visit, all commodes had ‘I am clean stickers’ and were visibly clean.

There was a trust wide policy for sepsis management. Staff received training as part of the trust’s key learning programme, which included all aspects of the Sepsis Care bundle and Sepsis 6. Sepsis 6 is a bundle of medical therapies designed to reduce the mortality of patients with sepsis. A Sepsis 6 box containing the basic supplies required to commence treatment of suspected sepsis was readily available on the ward.

Environment and equipment

The surgical ward had twenty available bed spaces containing fourteen beds, four reclining chairs and two trolleys. There were two single rooms, which were used primarily for privacy and dignity during admission interviews or if a patient required privacy due to the nature of their surgery, for example breast surgery or medical termination. The ward reported no mixed sex breaches.

The operating department consisted of a small waiting area, which due to the age of the building was not ideal. To mitigate this, one patient at a time was called to wait for their surgery. A volunteer worker supported patients in this area. There were two operating theatres, a recovery area, equipment storage and a sterile supplies drop-off and collection area.

Equipment within Fotherby Ward and theatres was stored appropriately and was accessible when needed. Equipment in regular use, such as observation trolleys, which included electronic blood pressure machines, heart rate, oxygen saturation and digital thermometers, were stored in the ward area.

During our visit to Fotherby Ward, we identified seven items of equipment, which were out of date for safety checks. We escalated this to the ward sister who immediately contacted an engineer. We saw all items had been checked prior to leaving the department.

There was a trust wide in-house medical physics equipment and calibration service. Staff told us they had not experienced difficulties accessing equipment or arranging repairs when needed.

During our inspection we reviewed the documented checks for resuscitation trolleys, anaesthetic trolleys and the difficult intubation (difficult airway access) trolleys and found them to be completed and signed every day. All disposable items on these trolleys were within their use-by date.

Product or safety alerts were shared with staff at the morning ‘huddle’ and information was stored in files within the ward and operating department for those not present. We did not witness a staff ‘huddle’ but did see information folders where available for staff.

Due to strict exclusion criteria, larger patients (bariatric) were not operated on at County Hospital Louth, this was because of increased risk of anaesthetic and post-operative complications.

There was separate male/female toilet and washing facilities on the ward. All had equipment available to raise the level of the toilet seat.

Assessing and responding to patient risk

All patients had a comprehensive pre-operative risk assessment. This was documented in an acute in-patient risk assessment booklet which included patient medical history and health questionnaire, plus a range of risk assessments including; malnutrition universal screening tool'
(MUST), body map and pressure ulcer risk (Waterlow), body mass index (BMI), bed rail requirement, falls risk, mental capacity and Hip and knee score for those undergoing joint replacement. We observed two patients in the pre-assessment area noted all assessments were completed and discussed with the patient.

Nursing staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores enable early recognition of patient deterioration by numerically grading the observations and prompting nursing or medical reviews for specific numerical scores. We reviewed three patients’ records post-operatively and found their observations had been clearly recorded and correctly scored.

The operating department at County Hospital Louth complied with the five steps to safer surgery as recommended by the national patient safety agency (NPSA) 2010. This includes, team briefing, sign in, time out, sign out and debriefing. The aim of the five steps to safer surgery was for teams to work collaboratively together to ensure patient safety.

In the operating department, we saw documentary evidence of the world health organisation (WHO) surgical safety checklist in use. The WHO is a simple checklist developed by the World Health Organisation, which reduces surgical risk through a series of checks, including confirming the patient’s identity, operation site, procedure and consent. It also included identification and dedicated role of all staff present. The completed WHO checklist was included in each patient’s anaesthetic and surgical record booklet. We saw completed WHO checklists for the two patients within the operating theatre.

Due to the strict admission criteria of the surgical department at County Hospital Louth patients with mental health problems were referred for treatment at Lincoln County Hospital, where there was access to psychology services. Staff had received ‘care of patients living with dementia’ training and were aware of the trusts ‘dementia care bundle’.

One of the toilet / shower areas on Fotherby was found to have an identified ligature risk. This was escalated to the nurse in charge. We saw a ligature risk assessment document dated August 2017 and a Fotherby Ward assessment. Areas were identified for local management. Ligature cutters were available on the ward.

**Nurse staffing**

County Hospital Louth reported their registered nursing staff numbers as of October 2017, as shown below. Fotherby Ward was staffed to support 20 beds.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louth Hospital</td>
<td>19.2</td>
<td>15.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

**Vacancy rates**

From November 2016 to October 2017 County Hospital Louth reported a vacancy rate of 10.5% (3.6 WTE) for nursing and midwifery staff in surgery. This is below the trust target of 11.5%.

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louth Hospital</td>
<td>11.5</td>
<td>10.5</td>
</tr>
</tbody>
</table>
(Source: Routine Provider Information Request (RPIR) Vacancy)

Senior managers told us recruitment across the trust was a continual on-going process. Cohort recruitment was in place for newly qualified staff. However, Lincoln County Hospital attracted the highest number.

**Turnover rates**

From November 2016 to October 2017 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 6.6% for qualified nursing and health visiting staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. County Hospital Louth reported a 0% turnover, with no leavers for the period November 2016 to October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louth Hospital</td>
<td>0</td>
<td>20.0</td>
<td>0</td>
</tr>
</tbody>
</table>

The turnover rate for all sites was within the trust’s target of 20% for an individual staff group.

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

**Sickness rates**

From October 2016 to September 2017 United Lincolnshire Hospitals NHS Trust reported a sickness rate of 4.5% for nursing staff in surgery, this equalled the trust’s target rate. A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>4.5</td>
<td>5.3</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>3.9</td>
</tr>
</tbody>
</table>

County hospital Louth sickness rate for qualified nursing and health visiting staff from October 2016 to September 2017 was below the trust’s target.

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

**Bank and agency staff usage**

From December 2016 to November 2017 the trust reported a bank and agency fill rate of 20.3% with a further 4.8% of shift remaining unfilled. A breakdown by staff type and location is shown below:

**County Hospital Louth**

<table>
<thead>
<tr>
<th>Nursing staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered</td>
<td>0</td>
<td>13 (1.3%)</td>
<td>1 (0.1%)</td>
<td>1,021</td>
</tr>
</tbody>
</table>

Data provided by the trust indicated one agency registered nurse had been employed, for one shift, on Fotherby Ward during the period December 2016 and November 2017. Senior staff told
us all shifts were covered by substantive staff and time off in lieu given.

The trust had a standing operating procedure for agency nurse induction, which included a competency assessment checklist, if required.

(Source: Routine Provider Information Request (RPIR) nursing bank agency)

Medical staffing

The trust reported their medical and dental staff numbers, as of October 2017, as shown below. For all sites, there were 391.5 whole time equivalent (WTE) planned staff and 348.5 WTE staff in post as of October 2017.

<table>
<thead>
<tr>
<th>Site</th>
<th>WTE Staff</th>
<th>Number in post, October 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>53.0</td>
<td>47.0</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>176.2</td>
<td>165.6</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>158.3</td>
<td>131.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing)

Vacancy rates

From November 2016 to October 2017, the trust reported a vacancy rate of 12.0% for medical and dental staff in surgery. The vacancy rate by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>12.0</td>
<td>14.9</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>12.0</td>
<td>9.3</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>12.0</td>
<td>9.4</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>12.0</td>
<td>14.2</td>
</tr>
</tbody>
</table>

Vacancy rates at County Hospital Louth was below the trust target

(Source: Routine Provider Information Request (RPIR) Vacancy)

Turnover rates

From November 2016 to October 2017 United Lincolnshire Hospitals NHS Trust reported an annual turnover rate of 12.2% for medical and dental staff. The trust has a voluntary turnover rate target of 7% and no individual staff group should be over 20%. The trust’s turnover rate for medical and dental staff is split by site below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Total leavers (WTE)</th>
<th>Target (%)</th>
<th>% annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>3</td>
<td>20.0</td>
<td>10.4</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>9.6</td>
<td>20.0</td>
<td>11.0</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>0.0</td>
<td>20.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>11</td>
<td>20.0</td>
<td>15.0</td>
</tr>
</tbody>
</table>

The turnover rate for all sites was within the trust’s target of 20% for an individual staff group.

(Source: Routine Provider Information Request (RPIR) Turnover)
Sickness rates

From October 2016 to September 2017 United Lincolnshire Hospitals NHS Trust reported an overall/average sickness rate of 1.7% for medical and dental staff in surgery. The trust’s target rate for sickness is 4.5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Target (%)</th>
<th>% sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grantham and District Hospital</td>
<td>4.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>4.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Louth Hospital</td>
<td>4.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>4.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Sickness rates for medical and dental staff at County Hospital Louth from October 2016 to September 2017 was 0.3%.

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

Bank and locum staff usage

Data provided by the trust for the period December 2016 to November 2017 showed minimum use of consultant locum (agency) staff with two consultant anaesthetist shifts and five consultant orthopaedic shifts utilised. Middle grade medical staff showed greater use with five within surgery and 85 within orthopaedic surgery, this reflected the lower percentage of registrar level employees across the trust.

Staffing skill mix

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

Staffing skill mix for the whole time equivalent staff working at United Lincolnshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>31%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>9%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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

(Source: NHS Digital Workforce Statistics)
A breakdown of medical staffing for County Hospital Louth was not provided. However, we were told the majority of consultants visited the hospital to complete their operating lists. There was a resident middle grade doctor rota for medical cover out of hours.

**Records**

Patients at County Hospital Louth had paper records, which were stored securely in locked trolleys. We saw patient’s medical notes placed name down to avoid inadvertently breaching confidentiality.

We reviewed two sets of patient notes on the Ward and two within the operating theatre department, found them to be in logical order, legible, and signed on each page as per medical records policy.

We saw where clinical investigations had been requested, completed and reported in a timely manner. For example, Magnetic Resonance Imaging (MRI) was consultant reviewed and reported within 24 hours. This was documented within the patient’s notes.

There was documentary evidence of relevant communication with other health professionals and the records reviewed included clear reference to patient’s allergy risks and included an evaluation of the criteria for discharge and recovery. This met clinical guidance in accordance with the national institute for health and care excellence (NICE).

Patients were given a discharge letter for their general practitioner (GP) on discharge from hospital. However, managers reported limited administrative support, which had led to some delays in clinic letters and communication with general practitioners. There was a business case in place to address this with a trajectory of clearing all backlogs within one month.

We did not see any patient records which were ‘end of life’ or who had ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) documentation. However, we were provided with the trust safety and quality dashboard outcome, which showed 100% compliance with DNACPR documentation, including decision, discussion with relatives, named consultant and review date information.

The safety and quality dashboard information provided showed 100% compliance with required documentation for risk assessments including bed rail requirement, falls risk assessment, pain management, pressure care risk assessment and MUST.

**Medicines**

The ordering, storage and administration of controlled drugs (CD) were in accordance with the Misuse of Drugs Act 1971 and the associated regulations. Areas visited had suitable cupboards to store controlled drugs. We checked stock levels on the ward and operating theatre and found them to be correct when compared to the CD record book.

Ward medicines were stored in locked cupboards. However, within the operating department the medicine cupboards were closed but not locked. We escalated this and were told this was normal practice for the department and cupboards were locked at the end of the working day.

Emergency drugs were provided in a sealed red box and were checked and signed by pharmacy. The earliest drug expiry date was on the outside of the box. On examination, the red emergency drug box in theatre recovery had two stickers with different expiry dates. This was escalated to the theatre manager who immediately checked the box. A previous expiry sticker had not been removed. We felt this could lead to confusion in an emergency.
We reviewed two prescription charts and found them to be clearly written and signed. Medicine administration was initialled.

**Incidents**

**Never Events**

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

From January 2017 to December 2017, the ULHT trust reported one incident classified as a never event for surgery. This was a retained foreign object post procedure. County Hospital Louth had reported no never events for this period.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 69 serious incidents (SIs) in surgery, which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Pressure ulcer meeting SI criteria with 26 (37.7% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with 10 (14.5% of total incidents).
- Slips/trips/falls meeting SI criteria with 10 (14.5% of total incidents).
- Treatment delay meeting SI criteria with 10 (14.5% of total incidents).

(Source: Strategic Executive Information System (STEIS))
There were no serious incidents reported by surgical services at County Hospital Louth. However, there was sharing and learning from incidents across the trust. We saw evidence of this in a communication folder and staff meeting minutes.

Staff understood their responsibilities in relation to duty of candour and the electronic incident reporting system required confirmation that duty of candour had been carried out. However, there was no documentary evidence of this for us to see at County Hospital Louth. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of ‘notifiable safety incidents’ as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.

Safety thermometer

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

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

Data provided showed 49 pressure ulcers, 31 falls with harm and nine catheter urinary tract infections from November 2016 to November 2017 within the Lincolnshire surgical services. The quality and safety notice board on Fotherby Ward showed no patient harms for the same period.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at United Lincolnshire Hospitals NHS Trust

The rate of pressure ulcers recorded in the patient safety thermometer has varied over time but there has been no upward or downward trend over the period. The rate of falls recorded has
fallen over the period and the rate of urinary tract infections in patients with a catheter (CUTIs) has remained similar.

(Source: NHS Digital)

**Is the service effective?**

**Evidence-based care and treatment**

The surgical service at County Hospital Louth provided care to patients based on national guidance including National Institute for Health and Care Excellence (NICE), Royal College of Surgeons (RCC), Association of Anaesthetists of Great Britain and Ireland (AAGBI). These were supported by local guidelines and policies. Compliance was measured through local and national audits and through presentation to the quality governance and patient safety meetings. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend patients with certain co-morbidities (multiple medical conditions) are reviewed pre-operatively by an anaesthetist. Examples include age, heart disease (myocardial infarction and angina), heart failure, ischaemic brain disease (stroke and transient ischaemic attacks). Patients referred to County Hospital Louth for surgery were low risk, without identified co-morbidities.

Staff had access to the trust intranet where all policies, protocols and procedures were stored. We were shown examples of policies available, which were up to date and included a review date.

Patients care needs were continually assessed using specific care pathways, delivering care in line with NICE quality standards and the Royal College of Nursing (RCN) guidelines. For example, the use of National Early Warning System (NEWS), complied with the recommendations within NICE guidance; ‘CG 50 acute illness in adults in hospital: recognising and responding to deterioration’. We saw where NEWS was utilised appropriately on Fotherby Ward with correct scoring of observation findings.

The adult in-patient risk assessment booklet included a range of national guidance information to assist staff provide up to date care. This included pressure ulcer recognition, stool chart and nutritional assessments. We reviewed two sets of medical/nursing notes and all appropriate risk assessments were completed.

An enhanced recovery procedure was in place for patients having hip, knee, or colorectal surgery. Enhanced recovery is an evidence-based approach that helps people recover quickly following major surgery. We saw documentation, which included information for the patient on what they could expect before and after surgery and discharge information. We also observed a hip and knee class for patients preparing for joint replacement surgery. This included information relating to the complete patient journey from preparation for admission to what to expect when going home. A multidisciplinary information DVD, funded by the orthopaedic business unit, had been produced by a local college, which covered information about all aspects of joint replacement.

The elective orthopaedic patients were prescribed pre-surgery analgesia (pain relieving tablets) and were consented for the national joint register as part of the enhanced recovery programme.

**Nutrition and hydration**

All patients had their nutritional status evaluated as part of pre-assessment.
Patients having surgery at County Hospital Louth were short stay, one to three days maximum. Dietetic information was provided at pre-assessment and as part of the enhanced recovery programme. This included advice about healthy eating pre-operatively, fasting times pre-surgery and returning to a normal diet post-surgery.

Hip and knee replacement patients were provided with a ‘high energy’ drink to have two hours before surgery. This did not apply to patients with diabetes.

Access via referral to a dietitian was available if required.

**Pain relief**

Patients spoke with on Fotherby Ward told us they had not experienced pain after their surgery and staff had frequently asked if they were comfortable.

Patients having knee or hip replacement surgery were prescribed analgesia (Pain relieving medication) from the evening before surgery and for five days post operatively. Additionally, intravenous analgesia was administered for 24 hours post-surgery. Staff told us this enabled patients to mobilise early.

Verbal and written advice was provided relating to pain management at pre-assessment.

We reviewed two prescription charts and found them to be clearly written and all medications administered were initialled.

**Patient outcomes**

**Relative risk of re-admission**

**Trust level**

From September 2016 to August 2017, the trust had a lower than expected relative risk of readmission for elective admissions when compared to the England/national average. However, when comparing the trust to the England average at specialty level (for the most common three specialties at the trust) Trauma & Orthopaedics patients had a higher than expected relative risk of readmission for elective admissions.

The trust had a lower than expected relative risk of readmission for non-elective admissions when compared to the England average. For all of the three most common specialties at the trust the relative risk of readmission for non-elective patients was lower than the England average.

**Elective Admissions – Trust Level**

![Graph showing relative risk of readmission for elective admissions across different specialties.](image-url)
Non-Elective Admissions – Trust Level

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

(Source: HES - Readmissions (01/09/2016 - 31/08/2017))

County Hospital Louth

From September 2016 to August 2017, County Hospital Louth had a lower than expected relative risk of readmission for elective admissions when compared to the England average. However, for non-elective admissions, the hospital had a higher than expected relative risk of readmission when compared to the England average.

Elective Admissions - County Hospital Louth

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

Non-Elective Admissions - County Hospital Louth

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

(Source: Hospital Episode Statistics)

Patient Reported Outcome Measures
In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee Replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17, the proportion of groin hernia patients who reported an improvement following surgery was similar to the England average.

The trust performed worse than the England average for the proportion of patients who reported an improvement or a worsening following surgery for hip replacements, knee replacements and varicose veins.

(Source: NHS Digital)

Specific data relating to PROMS at County Hospital Louth was not indicated. However, patients we spoke with on Fotherby Ward indicated a high level of satisfaction for their immediate post-operative period.

**Competent staff**

**Appraisal rates**

The trust provided appraisal rates for staff who required an appraisal from April 2017 to October 2017. As most appraisals are carried out at the end of the financial year, figures do not include all staff members. From April 2017 to October 2017 419 staff were required to complete an appraisal with 83.5% of these having received an appraisal. This was lower than the trust target of 85%.
A split by staff group can be seen in the graph below:

![Bar chart showing staff group completion of appraisals](image)

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

![Bar chart showing staff group completion of appraisals](image)

At County Hospital Louth, data provided indicated 31 staff within surgery were required to complete an appraisal with 51.6% of these having received an appraisal. The trust target was 85% for all staff. However, staff spoken with during our inspection told us they were up to date with their appraisals.

Managers responsible for appraisals within surgery at County Hospital Louth showed us their local records relating which indicated scheduled appraisal dates for all staff.
A split by staff group can be seen in the graph below:

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

The trust had an Induction and Core Learning Training Policy, January 2015. The document included core learning needs analysis, which outlined staff groups, initial training, refresher training, duration and methodology (Classroom/e-learning), required update period, additional requirements and accreditation status. Additionally, the policy included a standard operational policy for agency nurse induction and a competency checklist. We saw an example of the checklist.

All staff attended a corporate induction and local induction on commencement of employment at the trust. Additionally, new staff completed four weeks at supernumerary status. This enabled new staff to familiarise themselves with policies, procedures and the working routine within their workplace.

An induction folder was available on Fotherby Ward for bank and agency staff. However, use of agency staff at County Hospital Louth was rare. We were shown a copy of the induction handbook, which included working procedures, ward orientation and medicine administration.

Volunteer staff employed at the trust underwent a recruitment process, which mirrored the requirements for all other hospital staff (application form, disclosure and baring system checks and two references). There was an induction checklist specific to volunteers.

A volunteer working within the operating theatre department and had been instrumental in improving the patient experience whilst waiting, in the department, to have their surgery.

Medical staff had an annual budget for training / conference attendance to support their professional development. We spoke with an operating department physician’s assistant anaesthetist who could access medical funding to support continual professional development within his role. However, funding was reducing which meant there was a risk to the sustainability of the assistant’s role.

Nursing staff were required to apply to the trust for access to training or conference attendance. However, there were limited resources to support their application. The head of nursing told us
funding was available and each request was reviewed based on relevance and equality of access for all nursing staff.

Qualified nurses told us, support was available for completing their required registration revalidation.

**Multidisciplinary working**

Multidisciplinary working was evident with staff describing good collaborative working across multi professional teams. Examples included working with medical staff, allied health professionals (AHP) and the infection prevention and control (IPC) team. This was particularly evident within pre-assessment where staff engaged with a wide range of professionals and within the hip and knee class (pre-surgery class) which included input from all those involved in the patient’s journey.

During our visit to Fotherby Ward, we did not see a multidisciplinary ward round. However, we were assured by staff and patients that every patient was appropriately reviewed post operatively. Medical notes reviewed included documented ward round visits and assessments, including consultant review.

Staff on Fotherby Ward told us there was never a problem accessing medical support, if needed.

**Seven-day services**

Surgery was carried out over five days at County Hospital Louth with the operating department opening from 08:30 hours through to 21:00 hours. These hours represented an increase on previous opening hours of 08:30 to 18:00 and were part of a pilot to increase activity.

The operating department did not offer an out of hours or trauma service.

Fotherby Ward was open 24 hours over five and a half days up to Saturday mid-day. Services available included physiotherapy, radiology and pharmacy.

Other services were available Monday to Friday, on referral. For example, dietician or occupational therapy.

**Health promotion**

Information leaflets for surgical procedures carried out at Grantham and District hospital were available and given to patients at pre-assessment clinic. Leaflets included how to ensure patients were in the best health possible prior to admission to hospital through to diet and exercise post operatively.

Alcohol and smoking cessation information was available for patients. However, the trust did not provide smoking cessation products to patients.

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

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

Deprivation of Liberty safeguards training at the trust is completed as part of the Mental Capacity Act 2005 (MCA) level 2 training module. The trust reported that from April 2017 to October 2017 MCA level 2 training had been completed by 84.1% of staff within outpatients. This was lower than the trust target of 90%.
The trust set a target of 90% for completion of MCA level 2 training. A breakdown of compliance for MCA level 2 training for medical and dental staff in surgery from April 2017 to October 2017 is shown below:

Louth Hospital – medical and dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Louth Hospital met the trust target with 100% of medical and dental staff having completed MCA level 2 training.

A breakdown of compliance for MCA level 2 training for qualified nursing and health visiting staff in surgery from April 2017 to October 2017 is shown below:

Louth Hospital – Qualified nursing & health visiting staff (Qualified nurses)

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>19</td>
<td>20</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Louth County Hospital met the trust target for MCA level 2 training compliance with 94% of staff having completed the training.

Consent forms included a description of the procedure to be carried out and the range of possible post-operative complications. The consent forms for the two patient’s records viewed in the operating theatre had been fully completed and signed by a consultant and the patient.
Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family Test (FFT) response rate for surgery at United Lincolnshire Hospitals NHS Trust was 27%, which was similar to the England average of 29% from December 2016 to November 2017.

A breakdown of response rates by site can be viewed below:

Friends and family test response rate at United Lincolnshire Hospitals NHS Trust, by site.

![Bar chart showing response rates by site.]

The percentage of patients that would recommend the hospital to friends and family is split by ward below:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total Resp.</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Hospital Louth</td>
<td>185</td>
<td>94%</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Grantham &amp; District Hospital</td>
<td>252</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Lincoln County Hospital</td>
<td>983</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Pilgrim Hospital</td>
<td>1,566</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

In 10 out of 12 months, 100% of respondents on Fotherby Ward said they would recommend the hospital to friends and family. The response rate on Fotherby Ward was also the highest of any wards with 55% of eligible patients responding to the FFT survey.

(Source: NHS England Friends and Family Test)

All observed interactions between staff, patients and carers appeared compassionate with time provided for listening and responding to questions asked. Patients and carers told us staff were kind and helpful.
Emotional support

All the patients interviewed on Fotherby Ward spoke very highly of the support they had received during their pre- and post-operative period. Statements included ‘I have no complaints at all’ and ‘the staff can’t do enough for us’. They told us they felt safe and supported at all times.

Understanding and involvement of patients and those close to them

Patients told us all their treatment had been fully explained to them and their family and they were all encouraged to ask questions.

There was information provided about aftercare and rehabilitation with contact details for patients and relatives to use if they had any concerns. We observed a pre-operative knee and hip replacement class were patient’s questions and anxieties were addressed. Patients spoken with during the class told us it gave them confidence about what to expect and what they could do after surgery.

Patients told us information provided had been invaluable to them and their family with hints and tips to aid a safe recovery.

Is the service responsive?

Service delivery to meet the needs of local people

County Hospital Louth was able to meet the local demand for surgery with low risk patients being encouraged to choose this hospital for surgery, in preference of travelling to other sites within the trust. However, due to limited enhanced care options, the hospital had exclusions to surgery criteria.

The hospital was undertaking a twelve-week pilot study of increased operating hours to enable the site to increase activity and reduce the pressure on other ULHT sites for elective, low risk surgery. This pilot had been active for two weeks, which had included a period of severe weather cancellations. It was therefore not possible to evaluate the effect on meeting local service needs. However, there was an enthusiasm amongst most staff to embrace the increased activity.

Average length of stay

Trust Level – elective patients

From October 2016 to September 2017, the average length of stay for all elective patients at the trust was 2.6 days, which was lower than expected compared to the England average of 3.3 days.

When split by specialty the average length of stay for all three of the most common specialties (based on count of elective activity) at the trust was similar to the England average.
Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 5.2 days, which was similar to expected when compared to the England average of 5.0 days.

When split by specialty the average length of stay for two of the three most common specialties (based on count of non-elective activity) at the trust was similar to the England average. These were General Surgery and Urology. The average length of stay for non-elective Trauma and Orthopaedics patients was 7.3 days, which was lower than the England average of 8.9 days.

County Hospital Louth - elective patients

From October 2016 to September 2017 the average length of stay for all elective patients at County Hospital Louth was 1.3 days, which was lower than the England average of 3.3 days.

When split by specialty the average length of stay for all three of the most common specialties (based on count of elective activity) at the hospital was lower than the England average.
County Hospital Louth – non-elective patients

County Hospital Louth did not admit emergency or trauma patients for surgery.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

County Hospital Louth was able to meet the individual needs of patients. This was supported by the pre-assessment process.

The hospital had strict admission criteria, which meant patients requiring additional support were referred to one of the other main surgical sites at Lincoln County or Pilgrim Hospital. This included patients with physical or psychological disabilities.

The trust had not reported any mixed sex breaches with ward bays designated as male or female. Additionally, there was access to male and female toilet facilities.

The trust provided an interpretation and translation service available 24 hours a day, seven days a week through a contracted supplier. This service included face-to-face interpreting, telephone interpreting and written translation. Staff we spoke with were aware of this service but told us they had not had experience of using it.

There was information displayed regarding support available for patients living with dementia or had learning difficulties. Staff told us there was a learning disabilities nurse, based at Lincoln County Hospital, who they could contact if further support was needed.

Access and flow

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

From November 2016 to October 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was 56.2% compared to the England average of 69.9%. The trust performed consistently below the England average for Surgery in every month reported.

In October 2017 and November 2017, the trust did not submit RTT data to NHS England. This was agreed with NHS England due to an upgrade of the Medway patient administration system (PAS) which affected the accuracy of the trust’s reporting. This has been resolved by the trust in the agreed timescales.
Referral to treatment rates (percentage within 18 weeks) for admitted pathways, United Lincolnshire Hospitals NHS Trust

(Source: NHS England)

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

A breakdown of referral to treatment (RTT) rates for admitted pathways in surgery, at trust level, broken down by specialty is below. All six specialties at the trust performed below the England average for admitted RTT rates.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>74.7%</td>
<td>77.0%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>61.1%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>57.5%</td>
<td>61.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>47.3%</td>
<td>72.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>45.2%</td>
<td>64.4%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0.0%</td>
<td>83.1%</td>
</tr>
</tbody>
</table>

Senior managers told us they were taking steps to improve RTT. This included a review of all activity, additional outpatient sessions and ad-hoc clinics, the introduction of one-stop clinics and virtual nurse led clinics. The effectiveness of these actions was being monitored through a daily report on all 12 week waits, full consultant led harm reviews weekly and designated weekly cancer RTT and risk meeting. To facilitate the time commitment required these actions had been recognised and included within consultant job plans.

At County Hospital Louth, the twelve-week pilot study of extended surgical capacity was being monitored for effect on RTT. However, this was in the early stages of implementation.

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.
Percentage of patients whose operation was cancelled and were not treated within 28 days - United Lincolnshire Hospitals NHS Trust

Over the two years, the percentage of cancelled operations at the trust showed a declining trend and since quarter 3 of 2016/17 the trust's performance has been similar to the England average.

In the most recently reported quarter (Q2 2017/18) 3.8% of the 679 cancelled operations were not treated within 28 days which was lower than the England average of 6.8%.

Cancelled Operations as a percentage of elective admissions - United Lincolnshire Hospitals NHS Trust

Over the two years, the percentage of cancelled operations at the trust showed an upward trend, and was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

Summary of complaints

From October 2016 to September 2017 there were 188 complaints about surgical care, trust wide. The trust took an average of 69 working days to investigate and close complaints. The trust has an internal target to close 80% of complaints within 35 days. Of the 188 complaints, 130 had been closed at the time the data was provided and only 7.7% of these had been closed within 35 days. The trust has a further target to close 80% of complex complaints within 50 days, when taking this target into consideration 20.0% of all of the closed complaints were closed within 50 days.

At Louth Hospital there were three complaints. Of these, one had been closed at the time of reporting. The trust has an internal target to close 80% of complaints within 35 days and a further target to close 80% complex complaints within 50 days. The trust took 79 working days to
investigate and close the complaint, which was not within the target time of 50 days. Two
complaints were re-opened in the time period.

There were two complaints at Louth Hospital relating to communication with the patient and one
regarding a delay or failure in treatment or procedure.

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

Senior managers told us they took a pride in closing complaints within the expected timeline.
Responses were signed off by the clinical director or head of nursing.

Learning from complaints was shared at the morning staff huddles and monitored by the trust
quality team. We saw staff meeting minutes, which included reference to complaints, received.

Is the service well-led?

Leadership

Leadership at County Hospital Louth was through a clinical director, general manager, head of
nursing, operational and business management based at Lincoln County Hospital, Supported by
general surgery and orthopaedic heads of service, ward sister and the theatre manager. The
range of experience within the senior team enabled effective leadership of the surgical service at
the hospital.

Surgical division leadership at trust level had recently entered a period of stability following a two-
year period of several changes in general management. This was recognised by senior managers
as stabilising in terms of developing the service.

The majority of staff told us they felt local managers were visible, approachable, supportive and
they received appropriate support allowing them to undertake their jobs effectively. They were able
to name the chief executive and trust senior nurse, had seen them at trust meetings or received
communication from them.

Managers we spoke with were positive about the impact of quarterly multi-professional senior
leadership forums introduced in 2017. The forum, chaired by the chief executive officer, had
improved trust wide communication at a senior level. Additionally, ward sisters had a protected ten
minutes ‘time to talk session’ where patient safety and current risks could be addressed with fellow
managers.

Vision and strategy

The trust had a five-year strategy for all clinical services for 2014 to 2019 to support the delivery of
good quality patient care. The vision and strategy for surgical care was to provide comprehensive
planned services. Additionally, the trust had a staff and public engagement strategy called ‘Our
Ambitions 2021’. This was displayed around the trust.

The trust vision; working together to provide sustainable high-quality patient-centred care for the
people of Lincolnshire was underpinned by five key values; to be patient-centred, safety,
excellence, compassion and respect. During our inspection, we met and spoke with staff in pre-
assessment, on the surgical ward and operating theatres who demonstrated the trust’s values by
working together to provide a seamless service for patients.

Senior managers we spoke with outlined plans to meet the vision and strategy for the surgical
service at County Hospital Louth through evaluating the pilot study to increase elective surgical
Evidence appendix United Lincolnshire Hospitals NHS Trust

activity and reviewing nursing and medical establishments. Local leadership recognised the
demands placed on County Hospital Louth to increase activity and were positive about the future.

Senior managers we met with were able to describe challenges the service was experiencing and
actions being taken to support staff through some difficult times. This included recruitment,
managing an aging estate and the planned review of services across the trust. They told us they
wanted to ‘Continue providing a good community service’.

There was a people’s strategy, which sets out a vision for the workforce of the trust. It analysed
projected workforce activity and considers, for example the effect of an aging workforce and the
need to consider flexibility in order to retain skills and promote the careers of younger people.

Information relating to vision and values was displayed in the departments visited.

Culture

Staff were overwhelmingly positive about working at County Hospital Louth; they felt valued in
their work and felt there was community spirit at the hospital.

There appeared to be an open relationship between managers at a local level with staff feeling
able to discuss their concerns or make suggestions to their line or departmental manager.

Staff said they were encouraged to report incidents and concerns and would not be afraid to do
so.

Governance

From September 2017, the trust had introduced ward accreditation as its approach to measuring
the quality of care delivered to patients in the ward environment. There were standard operating
procedures in place to support the ward accreditation process with full Trust Board approval
gained in June 2017.

The governance structure had been reviewed with monthly governance meetings and quarterly
trust wide meetings established. The trust had appointed additional risk management staff to work
alongside departments,audit leads,matrons and the policy group to recognise and raise
concerns.

Trust matrons worked alongside ward sisters concentrating on quality and support of wards with
the accreditation process.

Management of risk, issues and performance

There was an electronic risk register in place for recording and managing risks. We looked at the
risk surgical services register during our visit, which included a description of each risk, date of
identification, review date, actions, named responsibility and RAG (red/amber/green) status. Risks
identified included staffing, estates, capacity and referral to treatment times (RTT) which reflected
those identified through our discussions with the senior management team.

From September 2017, the trust had introduced ward accreditation as its approach to measuring
the quality of care delivered to patients in the ward environment using multiple methods and
sources of data. In total 13 standards were monitored and a rating applied ranging from Red
through to Amber and Green to eventually Blue.

Information management

Service performance measures were reported and monitored. The ward managers and matrons
had access to a quality and safety dashboard at all times, which displayed performance measures.
The information was displayed on ward noticeboards. This meant staff and visitors could see at a glance how well wards were performing.

The trust published annual reports including for example a joint strategic needs assessment (JSNA), complaints, equality and diversity, safeguarding and an infection control annual report (DIPC). These were available on the trust's public website.

**Staff engagement**

Fotherby Ward and the operating theatres held team meetings, which were minuted. These provided relevant updates about the department, the division and the wider trust. A staff huddle took place at the beginning of each day for sharing and learning purposes. Staff told us this was a good opportunity to find out what was going on and discuss important issues. Nursing staff spoke positively of being involved in decisions and new ways of working, we saw evidence from staff meetings where local and trust developments had been discussed.

Staff at County Hospital Louth expressed some concern about information provided to them relating to the twelve-week increased elective activity trial. However, there was an enthusiasm amongst most staff for raising the profile of the hospital. We raised this with senior managers who were surprised to hear of the concern raised. They told us there had been frequent communication with staff at the site. However, they told us they would investigate and provide further support to the staff on this site.

Trust staff survey 2017 results showed a score of 3.6 with one indicating staff had little engagement and five indicating highly levels of staff engagement. This was slightly down on the 2016 result of 3.75.

The chief executive sent a weekly email to all staff. This included what was happening in the trust, information about national visits, awards given and health information such as the availability of the flu vaccine.

The trust had a ‘staff engagement on 2021’ strategy. The document outlined how staff were being engaged in discussions about the future of United Lincoln Hospitals NHS Trust (ULHT). A survey of staff had established common themes for the trust to consider when developing the 2021 five-year strategy. A key theme was to make better use of workforce, improving recruitment and retention of staff. Additionally, the survey gave an opportunity for staff to put forward ideas which could save money or increase revenue. For example, investment in renewable energy, improve clinical coding (this ensures a trust receives payment for work completed) and reduce waste. The survey indicated 64% of staff who took part knew ‘a little bit’ about the trust five-year plan. However, only 18% were confident the strategy would transform ULHT.

**Public engagement**

The trust had a ‘Public engagement on 2021’ strategy to consult with the public and service users about the future of United Lincoln Hospitals NHS Trust (ULHT). The trust had contacted over 110 groups and attended 57 public meetings. The key conclusion was people would prefer services closer to home wherever possible, although people accepted specialist services where the expertise was available. The public understood the current NHS issues including recruitment, finance and safety.

**Learning, continuous improvement and innovation**

The ward accreditation programme had been initiated in 2017 at Grantham and District hospital. Staff were positive about the improvements this would bring to County Hospital Louth. The trust had appointed quality improvement matrons to manage and oversee this project.